BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(25)11

AND

JAMIL NANDA (01-23061)

DETERMINATION OF A SUBSTANTIVE HEARING
13-16 OCTOBER 2025

Committee Members:	Mr Gerry Wareham (Chair/Lay) Mr John Vaughan (Lay) Ms Vivienne Geary (Lay) Ms Louise Gow (Optometrist) Ms Caroline Clark (Optometrist)
Legal adviser:	Ms Aaminah Khan
GOC Presenting Officer:	Ms Holly Huxtable
Registrant present/represented:	Yes and represented
Registrant representative:	Mr Nicholas Hall
Hearings Officer:	Ms Natasha Bance
Facts found proved:	Allegations 1-7 by virtue of the Registrant's admissions
Facts not found proved:	None
Misconduct:	Found for 1-6
Impairment:	Impaired
Sanction:	Suspension for 12 months (With Review)
Immediate order:	Imposed

ALLEGATION

The Council alleges that in relation to you, Jamil Nanda (01-23061) a registered Optometrist and Director of [redacted] Visionplus Limited:

1. On one or more occasions between 2022 and 2023, you failed to provide adequate supervision to pre-registrant optometrists in that you:

a. Provided insufficient supervision for 40 out of a potential 323 days as identified during the FRS investigation; and/or

b. Failed to adequately and/or appropriately ensure that pre-registrants obtained valid consent; and/or

c. Failed to adequately and/or appropriately ensure that pre-registrant optometrists did not examine more than the 12 patients per day; and/or

2. On one or more occasions between 2022 and 2023, you failed to adequately and/or appropriately ensure that your operator code was accurately registered for use in restricted category dispenses and collections; and/or

3. On one or more occasions between 2022 and 2023, you failed to adequately ensure that information provided by employees to customers, with regards to the costs associated with sight tests, was factually correct, in particular that customers were not adequately informed that the cost of a sight test was £25, and an optional OCT scan was available for an additional fee of £10; and/or

4. On one or more occasions between 2022 and 2023, you failed to adhere to established procedures in clinical practice in that when recording test results you calculated estimations instead of accurate measurements and made inconsistent manual adjustments; and/or

5. In February 2023, for one or more of the patients listed in Schedule A you and/or the pre-registration optometrists whom you are responsible for supervising:

a. Failed to record an adequate patient history; and/or

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

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

d. Performed assessments of both eyes in less than 25 seconds; and/or

e. Recorded answers to questions that were not asked; and/or

f. Recorded results for eye examinations that were not performed; and/or

g. Recorded different and/or inaccurate responses to what the patient had said; and/or

h. Recorded different and/or inaccurate details of what test was performed; and/or

i. Failed to provide adequate and/or appropriate advice; and/or

j. Failed to obtain an adequate history; and/or

6. Your actions as set out at 5e) and/or 5f) and/or 5g) and/or 5h) were dishonest in that you knowingly created false patient records; and/or

7. On or around 15 February 2023, during the consultation of Patient 7 you breached patient confidentiality and data protection, by failing to ensure that your screen of diary entries, which showed details of patients booked in on that day, giving their honorific, surname and first initial, was not visible to Patient 7;

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

DETERMINATION

Admissions in relation to the particulars of the allegation

1. Mr Hall, on behalf of the Registrant, formally entered admissions to the entirety of the Allegation, therefore each particular was found proved by virtue of those admissions, pursuant to Rule 46(6) of the General Optical Council (Fitness to Practise) Rules Order of Council 2013 ("the Rules"). Mr Hall confirmed that in relation to particular 6 (dishonesty), the admission was made on the basis of 'and' in each instance, rather than 'or'.

Background to the allegations

2. The Registrant is an Optometrist who was first registered on 23 January 2007. At the time of the events in question, the Registrant was one of the Directors of [redacted] Visionplus Limited, a branch of Specsavers ('the Practice').

3. On 17 July 2023, the General Optical Council ('the Council') received a referral regarding the Registrant from Specsavers Optical Group Limited. An internal investigation had been conducted by Specsavers' Financial Risk Support ('FRS') team, which had identified concerns regarding the Registrant's practice, including the Registrant's supervision of pre-registration

Optometrists and the volume of clinical interactions performed by the Registrant.

4.The FRS team initially completed a preliminary remote analysis of the Practice to understand why there was a disparity between the Practice's profits when compared with the Specsavers' group average. As part of the investigation, the FRS team arranged for 10 mystery shopper visits to be undertaken within the Practice between 3rd and 15th February 2023.

5.The mystery shopper visits were covertly recorded and the footage was reviewed by Dr A, Specsavers Professional Services Consultant. Dr A identified concerns that the two pre-registration Optometrists, for whom the Registrant was responsible for supervising, had both failed to obtain valid consent of their patients for their examination to be conducted by a pre-registration Optometrist, which was contrary to what the patient records indicated. Additionally, the two pre-registration Optometrists and the Registrant, all recorded results for examinations in the patient records which had not been performed or had recorded different results to those found. This was the basis for particular 5 of the Allegation.

6.Subsequently, the FRS team carried out a full internal investigation, which identified multiple concerns, as outlined in the FRS Investigation Report, dated 4 May 2023.

7.The FRS investigation identified further concerns regarding the volume of tests conducted and the duration of tests (being considerably shorter than would be expected). Sales data was reviewed between 1 March 2019 and 22 March 2023 and found that the Registrant was regularly exceeding the benchmark number of 28 clinical interactions per day and on some dates exceeded 50 per day. Additionally, the FRS investigation found that the pre-registration Optometrists were regularly exceeding the 12 tests per day set by the College of Optometrists guidance.

8.In addition, the FRS investigation identified concerns regarding whether the Registrant was providing adequate supervision of the pre-registration Optometrists that he was responsible for supervising. It found that there were occasions where the Registrant was supervising more than three pre-registration Optometrists at a time.

9.A further concern was that the Registrant's code for Socrates (the Practices' computer system) had been used a significant number of times to process or approve restricted dispenses (3,283) and collections (3,232) for customers under the age of 16. Given the volume of these clinical interactions over that period, particularly when the Registrant was examining a high number of patients himself, it was considered that other employees may have been using the Registrant's operator code.

10. Additionally, it was noted that during the mystery shopper footage, patients were informed that the cost of the sight test was £35, rather than being informed of the actual cost being £25, with an optional £10 for the OCT scan.

11. As part of the Council's investigation, an expert report was obtained from Dr Anna Kwartz, who reviewed the mystery shopper interactions. Dr Kwartz identified broadly similar concerns as the FRS team, as set out in her report dated 17 April 2025.

The hearing

12. The Committee was not required to make any findings in respect of the facts given that the Registrant made full admissions to the entirety of the Allegation. The case therefore proceeded to the misconduct and impairment stages.

13. Ms Huxtable opened the case on behalf of the Council and took the Committee through the relevant background to the case, as summarised above, with reference to documents in the Council's bundles. The Council's bundles included the referral from the Specsavers Optical Group Limited in July 2023, witness statements and exhibits from Mr B, Senior FRS Consultant, Dr A, Professional Services Consultant and Mr C, FRS Consultant and the expert report of Dr Kwartz. Given the Registrant's admissions these witnesses did not attend to give evidence. The Committee was also provided with patient records and the mystery shopper footage.

14. The Committee was provided with a bundle on behalf of the Registrant, which included material relevant to remediation and the impairment stage, namely a reflective statement, reflections following the completion of courses, numerous testimonials from colleagues, CPD certificates and statements, the Registrant's Personal Development Plan (PDP) and CV, disciplinary outcome letter and a clinical outcomes report.

15. The Registrant gave evidence, expanding upon his written reflective statements, and was questioned by his representative Mr Hall, Ms Huxtable, on behalf of the Council and the Committee.

16. In summary, the Registrant's evidence was that he became a Director in 2017 and increased his share in the Practice in 2019. After he was suspended in August 2023, he subsequently received a 12 month written warning from Specsavers, and thereafter he went back to practising but worked with his fellow Directors to address all of the concerns, including his habit of working excessive hours. The Registrant made changes to the clinics of fixed appointment times, rather than being rolling clinics, which reduced the number of patients.

17. The Registrant explained that the two pre-registration Optometrists involved in the mystery shopper exercise had been training for just under two years

and were at the OSCE (Objective Structured Clinical Examination), the final exam stage. They had taken on more trainees than they should have because the assessments of some had been delayed due to COVID-19. The Registrant accepted in his evidence that it was his responsibility as a supervisor to ensure that the pre-registration Optometrists did not see too many patients and he did not know the guideline number at the time, nor did he monitor the data.

18. The Registrant stated that his actions were not financially motivated and that the main issue was to hit the targets that were set by Specsavers, as it was encouraged by regional directors that they should see more patients and increase the number of OCTs performed. The Registrant accepted that he had succumbed to these commercial pressures.

19. The Registrant was asked what he thought was wrong with recording that a test had been performed when it had not. The Registrant stated that this affected patient care and led to the records being false or inaccurate, which can cause issues with patient safety, as this would be inaccurate for continuing care. The Registrant acknowledged that it would also breach trust for the patient, as they depend upon Optometrists and it failed to maintain standards or give the patient the correct level of care. The Registrant was asked about what the public would think about his conduct and he acknowledged that it would damage the reputation of the profession.

20. The Registrant gave evidence regarding the reflection and remediation that he had undertaken, which included courses that he had attended on supervision, clinical courses and on probity and ethics. The Registrant explained to the Committee how he had completed an individual reflection after each course. The Registrant explained how he had implemented changes when supervising pre-registrant Optometrists and followed a Supervisor Plan. He further explained his PDP (Personal Development Plan), the professional certificates that he had obtained and his plans for future development.

21. The Registrant gave evidence regarding how he had changed his practice and that the biggest change was to the clinics, changing to scheduled appointments and the increased time that he spent testing, with greater patient interaction. He now ensures that pre-registrant Optometrists have many fewer patients and he has increased his supervision of them, checking more of their tests. The Registrant explained the data in the Clinical Outcomes Report, which showed that he was now only testing about 14 patients per day.

22. The Registrant explained in his evidence that his conduct was out of character and was not his usual practice. He was going through a lot of personal issues at the time, as there had been [redacted]. The Registrant gave evidence that he felt '*very worked up and distracted*' at the time of the mystery shopper interactions. He stated that if he faced personal difficulties again in future he would take time out and not test.

23. The Registrant stated that he had reflected almost every day since on what had happened, and realised the impact upon patient care, the public, the profession and colleagues. He stated that he would never put himself in this position again or do anything to jeopardise patient safety.

24. The Registrant stated in answer to the Committee's questions, that he had been defensive in his investigation interview as he felt very vulnerable at the time and threatened. However, he had since reflected and now accepted that Dr A's comments regarding the Registrant's practice had been correct. The Registrant explained that he had previously been praised by Specsavers for the high number of tests that he performed and that management came into the Practice in 2019 to give him a box of chocolates for having the highest number of tests. However, he accepted now that this was the wrong approach and he would not go back to that. He now takes approximately 25 minutes per test and by testing less he is able to better support the pre-registration Optometrists and it is now a better work environment.

25. Mr Hall made an application for the part of the Registrant's evidence dealing with his difficult personal circumstances to be heard in private, under Rule 25, which the Committee agreed to. Ms Huxtable, on behalf of the Council, had no objection.

26. The Committee then heard submissions, with the agreement of the parties, on the misconduct and impairment stages together. However, it considered and determined these issues, separately and in turn, as set out below.

Misconduct

27. The Committee heard submissions on misconduct from Ms Huxtable, on behalf of the Council, and from Mr Hall, on behalf of the Registrant.

28. Ms Huxtable invited the Committee to find that the facts admitted by the Registrant and found proved by the Committee, amounted to misconduct.

29. Ms Huxtable stated that there was no strict definition of misconduct. She referred the Committee to the case law on misconduct, including the case of *Roylance v General Medical Council (No.2)* [2000] 1 A.C. 311, where, at paragraph 35, Lord Clyde stated:

> *"Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed in the particular circumstances."*

30. Ms Huxtable highlighted the guidance from the cases of *Remedy UK Ltd v General Medical Council [2010] EWHC 1245 (Admin),* which states that misconduct is of two principal kinds, firstly sufficiently serious misconduct in the exercise of professional practice or conduct that is morally culpable or otherwise disgraceful. Ms Huxtable submitted that the Council's position is that this case falls within both of these limbs.

31. Ms Huxtable referred the Committee to the cases of *R (Calhaem) v General Medical Council [2007] EWHC 2606 (Admin) and Nandi v GMC* [2004] EWHC 2317 (Admin), where Collins J held that the conduct must be serious and the adjective "serious" must be given its proper weight. This had been described as conduct that fellow practitioners would find deplorable.

32. In determining misconduct, Ms Huxtable referred the Committee to the Council's "Standards of Practice for Optometrists and Dispensing Opticians", effective from April 2016. She submitted that the Registrant has departed from the following standards by virtue of her conduct:

- Standard 1 – listen to patients and ensure that they are at the heart of the decisions made about their care.
- Standard 2 – communicate effectively with your patients.
- Standard 7 – conduct appropriate assessments, examinations, treatments and referrals.
- Standard 8 – maintain adequate patient records.
- Standard 16 - Be honest and trustworthy.
- Standard 17 - Do not damage the reputation of your profession through your conduct.

33. Ms Huxtable submitted that the conduct in this case was serious and would be considered deplorable, therefore amounts to misconduct.

34. Mr Hall in his submissions on misconduct informed the Committee that the Registrant did not dispute that the conduct amounted to misconduct. However, he made submissions regarding the severity and the degree of the misconduct. The Registrant had made admissions at an early stage. He reminded the Committee that there was a scale of dishonest conduct that can take various forms. He submitted that there were a number of factors in this case indicating that the Registrant's conduct was at the lower end of the scale, particularly that there was no evidence of a cover up, in that he was not hiding clinical failings and that the dishonesty *ipso facto* stems from the fact that the records were incorrect.

35. Mr Hall reminded the Committee that admitting dishonesty does not require the Registrant to have appreciated that his own conduct was dishonest. This was not pre-meditated or targeted dishonesty, but rather arose from a lapse of judgment stemming from the Registrant's difficult personal circumstances

during that period. The dishonesty allegation relates to four patients (Patients 3, 5, 6 and 7) that the Registrant saw over a brief period of about one week. Furthermore, Mr Hall submitted that the conduct was not financially motivated. It was an error of judgment in a very busy clinical setting, which was a difficult environment for the Registrant to be in. Additionally, Mr Hall submitted that there was no evidence of patient harm, thankfully, arising from the conduct.

36. Mr Hall concluded that in relation to the dishonesty, it was accepted that it was serious misconduct but not necessarily the most serious type of dishonesty and invited the Committee to take a more nuanced approach.

37. The Committee heard and accepted the advice of the Legal Adviser, who reminded the Committee that misconduct was a matter for its own independent judgement and no burden or standard of proof applied at this stage. Further, that the Committee needed to consider whether the conduct was sufficiently serious to amount to professional misconduct.

The Committee's Findings in relation to misconduct

38. In making its findings on misconduct, the Committee had regard to the evidence it had received to date, the submissions made by the parties, and the legal advice given by the Legal Adviser.

39. The Committee considered the Standards for Optometrists and considered that all of the standards referred to by the Council applied in this case (set out in paragraph 32 above) and had been breached by the Registrant's conduct.

40. Additionally, the Committee considered that standard 3 (obtaining valid consent) applied in relation to the Registrant's failure to ensure that the pre-registration Optometrists under his supervision had obtained consent. It also found that standard 9 (ensure that supervision is undertaken appropriately) was relevant and had been breached by the Registrant's conduct.

41. The Committee considered the issue of misconduct in relation to the range of conduct covered by the Allegation, considering each particular of the Allegation in turn.

Particular 1

42. This relates to the failure of the Registrant to provide adequate supervision to the pre-registrant Optometrists that he was responsible for, by providing insufficient supervision on days where he had more than 3 pre-registration Optometrists to supervise, failing to adequately ensure they were obtaining valid consent from patients and failing to ensure they did not examine more than 12 patients per day.

43. The Committee considered that the Registrant's conduct in this particular fell far short of the standards that were expected of a reasonably competent Optometrist. The Committee took the view that providing inadequate supervision to pre-registration Optometrists was serious as it had an impact upon their standard of training and thereby potentially compromising patient safety. The Committee noted that one of the pre-registration Optometrists in the mystery shopper interaction completed an eye test in less than 9 minutes, which was considerably less time than would be expected and there were other clinical concerns identified in their examinations.

44. Additionally, by failing to limit the number of patients seen by the pre-registration Optometrists, as required by the College of Optometrists guidance, the Registrant was not ensuring that standards were maintained and in the view of the Committee was valuing throughput in running the Practice above patient care.

45. In relation to failing to ensure that pre-registration Optometrists obtained valid consent for them to carry out the examinations, the Committee considered that this was misconduct, which was serious, as it lacked transparency and removed the choice from the patient, as some may have wanted to refuse to provide that consent.

46. For the above reasons, the Committee concluded that this conduct was serious and would be considered deplorable by fellow practitioners. Accordingly, the Committee found that it amounted to misconduct.

Particular 2

47. Particular 2 of the Allegation relates to the Registrant failing to ensure that his operator code was accurately used for restricted category dispenses and collections. It was apparent that other employees had access to and used his code, thereby undermining the intended safeguards and integrity of the records.

48. The Committee considered that this was conduct that fell far short of what was expected as it showed a disregard for the following of the correct rules and procedures relating to restricted dispensing. The Committee considered that there were important reasons why these restrictions were in place and should be adhered to.

49. The Committee noted that the Registrant's explanation was that he had left his code logged in to the system and that it was then misused by others. The Committee considered that if true, this was careless in the extreme, particularly as it occurred on multiple occasions rather than one-off incidents. The Committee considered that this was a further example of conduct of the Registrant failing to ensure standards were maintained and putting the throughput of the Practice above the requirements for restricted dispensing.

50. For the above reasons, the Committee concluded that this conduct was serious and would be considered deplorable by fellow practitioners. Accordingly, the Committee found that it amounted to misconduct.

Particular 3

51. Particular 3 relates to the misleading information that was given to patients regarding the cost of the sight test and a lack of transparency regarding the OCT scan being optional. The mystery shopper footage showed that eight out of the ten patients were incorrectly informed that the cost of the sight test was £35.

52. The Committee considered that this conduct fell far below the standards to be expected of a reasonably competent Optometrist, as the information being provided was misleading to patients. By not ensuring that it was clear to patients that the OCT test cost was optional, it removed the option from patients to decline that aspect of the test.

53. The Committee considered that this conduct involved a fundamental breach of trust with patients to be open and transparent regarding pricing of services offered and therefore regarded it as serious. Accordingly, the Committee found that it amounted to misconduct.

Particular 4

54. This particular relates to the Registrant failing to adhere to established procedures in clinical practice, in that, when recording test results for unaided vision and best corrected visual acuity, he calculated estimations instead of recording the accurate measurements and made inconsistent manual adjustments. This occurred in respect of the four patients that the Registrant examined in the mystery shopper footage, which took place between 7 February 2023 and 15 February 2023.

55. The Committee noted the explanation that the Registrant had given during the investigation for his method of testing but that on reflection he had accepted in his evidence the comments of Dr A. Additionally, the Committee noted that the expert witness Dr Kwartz stated in her report that she did not agree with the Registrant's rationale for documenting visual acuities of 6/7.5 as 6/6 because the room is too long, because modern projector charts are calibrated for the length of the room. Furthermore, Dr Kwartz considered that the Registrant's approach of documenting an assumed value for his patients' unaided visions to be '*totally inappropriate*.'

56. The Committee considered that the conduct in this particular relates to the fundamentals of conducting an appropriate eye test, namely measuring and

recording vision accurately. The Committee considered that this conduct fell far below the standards expected of a reasonably competent Optometrist and would be considered deplorable by fellow practitioners. Accordingly, the Committee found that it amounted to misconduct.

Particular 5

57. Particular 5 of the Allegation relates to the seven patients examined in the mystery shopper footage, four of whom were examined by the Registrant and three by pre-registration Optometrists that the Registrant was supervising. In each examination clinical concerns were identified, as set out in the Allegation.

58. The Committee noted that the expert witness Dr Kwartz stated that:

> "*16.7.3. Having watched the footage and reviewed the records of Patients 3, 5, 6 and 7, I am very critical of the standard of Jamil Nanda's patient records and consider that, in many instances, they do not provide a true reflection of the examination that he performed. For example: he recorded information in patients' histories that he had not elicited (eg general health, medication, driver status, headaches, diplopia), failed to record information that his patient gave him (eg headaches) and documented test results when he had not performed the relevant examination (eg cover test, near acuity, unaided vision, ophthalmoscopy). These erroneous entries not only have potential implications for patient care, but represent a significant issue of probity and truthfulness. I consider that as there are multiple errors across each of the patient records (Patients 3, 5, 6 and 7), Mr Nanda's standard of record keeping fell far below the required level*."

59. Dr Kwartz also had significant concerns regarding the Registrant's direct ophthalmoscopy technique in that his examination was very brief, not adequate and that he had recorded results of examinations that he had not conducted, which in her opinion was conduct that fell far below the required level and was a significant departure from the standard expected.

60. The Committee considered that the Registrant's conduct in this particular fell far below the standards expected of a reasonably competent Optometrist. It was serious as the Registrant's failings concerned multiple errors and resulted in the records of four patients being false and inaccurate. Accordingly, the Committee found that it amounted to misconduct.

Particular 6

61. Particular 6 of the Allegation relates to the Registrant's conduct in sub-particulars 5e), 5f), 5g) and 5h) of the Allegation being dishonest, in that he knowingly created false patient records.

62. The Committee was mindful that dishonesty can range in seriousness, however considered that the dishonesty in this case was particularly serious because it occurred in relation to the Registrant's practice as an Optometrist. The Registrant accepted that he had knowingly created false patient records, in respect of four patients, by for example, recording results for eye examinations that had not been performed.

63. The Committee considered the submission of Mr Hall that this was not dishonesty to go back and cover up a clinical error. Whilst that may be the case, the Committee considered that it was still intended to mislead by concealing omissions in the Registrant's clinical practice, in that he recorded results for examinations that were not performed and answers to questions that were not asked. The Committee considered that this conduct would render the patients records false and unreliable for any practitioner viewing them and would not be apparent in any audit.

64. Although there was no evidence of direct harm to those four patients by the Registrant's conduct, the Committee was satisfied that there was a risk of harm to them from their records being inaccurate, as future practitioners rely upon them to manage patient care. The Committee considered that recording false information in patient records undermines the integrity of the patient record and renders them unreliable for future colleagues. Furthermore, it breached the trust between the Registrant and his patients and was damaging to the reputation of the profession. The Committee noted that this was not an isolated incident of dishonesty, as it related to four different patients on different occasions, with multiple concerns in each patient interaction.

65. For the above reasons, the Committee concluded that this conduct was serious and would be considered deplorable by fellow practitioners. Accordingly, the Committee found that it amounted to misconduct.

Particular 7

66. This aspect of the case relates to the Registrant breaching patient confidentiality and data protection by failing to ensure that his screen was not visible to Patient 7. It could be seen from the mystery shopper footage of the examination with Patient 7 that diary entries were visible on the Registrant's screen, which showed the details of other patients booked in on that day.

67. The Committee considered that his conduct fell below the standards expected of a reasonably competent Optometrist. However, in considering the seriousness of this matter, the Committee had regard to the relatively brief length of time that the data was displayed on the Registrant's screen, the

limited nature of the data (effectively names and the fact that they had an appointment) and it was not clear whether the patient present was able to read the information on the screen. For these reasons, the Committee was not satisfied that this was a sufficiently serious breach of standards so as to amount to misconduct.

68. In relation to particulars 1 to 6 of the Allegation, which had been admitted and proved, the Committee was satisfied that the Registrant's misconduct fell far below the standards of what was proper in the circumstances, which was serious and was therefore misconduct.

69. The Committee was satisfied that in the circumstances, the Registrant's actions in particulars 1-6 were serious and would be considered wholly unacceptable and deplorable by fellow practitioners. Accordingly, the Committee was satisfied that the facts that had been admitted by the Registrant and found proved in those particulars, amounted to misconduct.

Impairment

70. The Committee next considered whether the fitness to practise of the Registrant was currently impaired, as a result of the misconduct found.

71. In her submissions on impairment, Ms Huxtable reminded the Committee that impairment was a forward looking exercise and that the purpose of fitness to practise proceedings is not to punish the Registrant for past wrongdoings but to protect the public from the acts of those who are not fit to practise.

72. Ms Huxtable referred the Committee to the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry, which was approved in the case of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (Admin), namely that impairment may be found where a Doctor (but applicable to Optometrists) has either in the past, or is liable in future, to:

    a. put a patient(s) at unwarranted risk of harm, and/or
    b. brought the profession into disrepute, and/or
    c. breached one of the fundamental tenets of the profession and/or
    d. acted dishonestly.

73. Ms Huxtable submitted that limbs (a), (b), (c) and (d) of this test are all engaged in this case. She submitted that the misconduct demonstrates not only serious failings in the level of care provided to patents 1 - 7, but also a willingness on the part of the Registrant to produce false patient records. She submitted that the Registrant's behaviour presents a clear risk of harm to the public, brings the profession into disrepute and breaches a fundamental tenet of the profession.

74. Ms Huxtable submitted that the Registrant's conduct had fallen far below the core standards expected of a reasonably competent Optometrist and that inaccurate patient records could cause serious harm to patients, be misleading for other practitioners who may conclude that a patient's condition is more or less serious as a result.

75. Ms Huxtable referred to the case law on impairment including the cases of *Professional Standards Authority v Health and Care Professions Council and Ajeneye* [2016] EWHC 1237 (Admin), which stated that deliberate dishonesty must come high on the scale of misconduct and *GMC v Armstrong* [2021] EWHC 1658, which suggested that it is rare for a person who has acted dishonestly to escape a finding of impairment.

76. Ms Huxtable submitted that it was the Council's position that a finding of impairment was required both on public protection grounds and in the wider public interest, in order to maintain public confidence in the profession, which would be undermined if a finding of impairment was not made.

77. Ms Huxtable acknowledged that the Registrant has undertaken some remediation and provided numerous positive testimonials. She acknowledged that in respect of the clinical failings these could be remediable. However, she submitted that dishonesty was a serious issue which was was not easy to remedy. Ms Huxtable stated that the Council's position was that the Registrant had not yet undertaken sufficient remediation to alleviate the ongoing risk of harm to patients.

78. Mr Hall, on behalf of the Registrant, invited the Committee to find the Registrant impaired on public interest grounds only. Mr Hall submitted that the Registrant was not impaired on public protection grounds, as he has sufficiently remediated so as to not impose a significant risk of future harm to the public or be liable to act in a dishonest manner again. It was accepted that the Registrant was impaired on public interest grounds by virtue of the dishonesty allegation.

79. Mr Hall highlighted that the Registrant had been practising since August 2023 and that it could be seen from the employment disciplinary letter how seriously the issues were taken and how out of character they were. In those two years since the Registrant has restructured the systems in the Practice and has also reflected and retrained. He has successfully supervised pre-registration Optometrists in the last two years and moved them through training to being qualified. Mr Hall invited the Committee to put the conduct into the context of the Registrant's unblemished 20 year career, with reference to the positive testimonials that have been provided.

80. Mr Hall highlighted the Registrant's reflective statements, which he described as incredibly detailed, his clinical development, relevant CPD, and future

plans. He submitted that the Registrant had developed insight into his actions and disagreed with Ms Huxtable's comment that it was 'intrinsically dishonest'. Mr Hall submitted that whilst dishonesty can be difficult to remediate, it was not impossible and the Registrant had done so.

81. Mr Hall submitted that the Registrant's reflections were not superficial and whilst the Committee may consider that his written reflections were more detailed than in his oral evidence, he invited the Committee to bear in mind how stressful and unfamiliar these proceedings are for registrants and asked the Committee not to underestimate how difficult it can be to elucidate insight. Mr Hall submitted that the Registrant has not shied away from his dishonesty.

82. Mr Hall acknowledged that an ordinary member of the public would expect a finding of impairment for dishonesty and that a finding of impairment itself was a sanction.

83. The Committee accepted the advice of the Legal Adviser who advised the Committee that the question of impairment was a matter for its independent judgement taking into account all of the evidence it has seen and heard so far. She reminded the Committee that a finding of impairment does not automatically follow a finding of misconduct and outlined the relevant considerations set out in the case of *Cohen v GMC* [2008] EWHC 581(Admin), namely whether the conduct is remediable, whether it has been remedied, and whether it is likely to be repeated. The Legal Adviser also highlighted the four limbs in the *Grant* case.

The Committee's findings on impairment

84. In making its findings on current impairment, the Committee had regard to the evidence it had received to date, including the oral evidence of the Registrant, the submissions made by the parties, and the legal advice given by the Legal Adviser.

85. The Committee considered the factors in the *Cohen* case, namely whether the Registrant's conduct was remediable, whether it had been remedied and whether the conduct is likely to be repeated in future.

86. The Committee noted that the misconduct was wide ranging in nature, including record-keeping and clinical concerns, whilst very serious may be more easily remedied. The misconduct also included dishonesty, which was more difficult to remediate.

87. The Committee considered whether the Registrant had remediated the misconduct since it occurred in 2022 and 2023. The Committee had regard to the oral evidence of the Registrant and the documentation provided by him. It noted the steps that the Registrant has taken in order to remediate, which include reflecting, as set out in his reflective statement, and the relevant CPD

undertaken, including on supervision, clinical training and on probity and ethics. The Committee also acknowledged the admissions that the Registrant has made in these proceedings and the numerous positive testimonials. However, the Committee considered that the testimonials from current employees and pre-registration Optometrists could only be given limited weight given the ongoing training and employment relationship.

88. The Committee acknowledged that the Registrant had made changes to his practice and changed systems within the Practice, such as moving to scheduled appointments, examining fewer patients and taking longer to test. However, the Committee was of the view that the Registrant in his evidence had not demonstrated that he had fully reflected on the motivations for his conduct. When considering why the misconduct occurred, the Committee noted that the Registrant had placed much emphasis upon his difficult personal circumstances and maintained that the period in question was not his usual practice and out of character.

89. However, the Committee noted that at least some aspects of the Registrant's practice appeared to be long-standing, for example, that he had previously been rewarded by Specsavers for the high number of tests conducted and his reputation for being a '*testing machine'*. The Committee also did not understand how the difficult personal circumstances that the Registrant explained he had experienced around that time had led to him acting in the manner in which he did, particularly in relation to the dishonesty. The Committee had concerns as to whether the Registrant understood or had taken full responsibility for his actions. The Committee considered there was evidence that the root cause of the Registrant's misconduct appeared to be of longstanding and ingrained, and that he had yet to fully acknowledge his pattern of behaviour.

90. The Committee therefore concluded that the Registrant had only demonstrated limited insight into why his misconduct occurred and therefore how to avoid it in future. Additionally, the Committee also considered that the Registrant lacked developed insight into the impact of his inadequate supervision upon the pre-registration Optometrists and the profession. The Committee therefore found that the Registrant has not yet fully remediated.

91. The Committee turned to consider the likelihood of repetition. The Committee noted that it was now over two years since the misconduct occurred and there had been no further concerns raised and the Registrant had undertaken some reflection and remediation. However, the Committee was concerned, given its findings in relation to the Registrant's insight, that until the insight and remediation had developed further, there would remain an ongoing risk of repetition. The Committee concluded that the risk of the Registrant repeating the misconduct remained. Accordingly, the Committee determined that the Registrant's fitness to practise was impaired on public protection grounds.

92. The Committee next considered the issue of the public interest and had regard to the case of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (admin), particularly the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry. The Committee agreed with the submission of Ms Huxtable that limbs (a), (b), (c) and (d) of this test are engaged in this case, namely conduct which puts patients at unwarranted risk of harm, brings the profession into disrepute, breaches a fundamental tenet of the profession and is dishonest. The Committee considered that these limbs of the test were engaged on the Registrant's past conduct in relation to the misconduct found proved and given the ongoing risk of repetition were also engaged on the basis of being 'liable in future' to occur.

93. The Committee considered the extent and seriousness of the Registrant's misconduct. The Committee considered it serious that it related to a range of concerns, including clinical concerns, the accuracy of patient records, lack of supervision of pre-registration students and dishonesty. Furthermore, these were not isolated incidents but were repeated, including the dishonesty, and directly affected four of the Registrant's patients. In the Committee's view the dishonesty in this case breached the trust of the Registrant's patients, and was a breach of fundamental standards, as set out above.

94. The Committee was of the view that given the seriousness of the conduct, the public would be concerned and public confidence in the profession would be undermined, if a finding of impairment was not made. The Committee determined that it was necessary to make a finding of impairment in this case in order to maintain confidence in the profession and in order to uphold proper professional standards.

95. The Committee considered the overarching objective, which is to protect, promote and maintain the health, safety and well-being of the public, to protect the public by promoting and maintaining public confidence in the profession and promoting and maintaining proper professional standards and conduct. The Committee was of the view that all three limbs of the overarching objective were engaged in this case.

96. Accordingly, the Committee found that the Registrant's fitness to practise as an Optometrist is currently impaired both on public protection and public interest grounds.

Sanction

97. The Committee went on to consider what would be the appropriate and proportionate sanction, if any, to impose in this case. It heard oral submissions from Ms Huxtable on behalf of the Council and Mr Hall on behalf of the Registrant. Further evidence was placed before the Committee at this stage of the hearing on behalf of the Registrant, namely ten further testimonials and

an email from the Registrant containing his reflection and response to the Committee's determination on impairment.

98. Ms Huxtable reminded the Committee that the purpose of a sanction is to protect the public and it is not intended to be punitive, although it may have that effect. Furthermore, that the impact upon the Registrant was a secondary consideration to the public interest. When deciding the appropriate sanction Ms Huxtable invited the Committee to have regard to the overarching objective and the principle of proportionality.

99. Ms Huxtable referred the Committee to the Council's Hearings and Indicative Sanctions Guidance (HISG). Ms Huxtable submitted that the factors in paragraphs 22.4 – 22.6 of the HISG may assist the Committee, which deal with dishonesty. Ms Huxtable submitted that a finding of dishonesty was particularly serious where it relates to clinical practice and record-keeping.

100. In relation to mitigating factors, Ms Huxtable highlighted that there had been no evidence presented of actual patient harm, full admissions, a degree of targeted remediation, positive testimonials and no prior fitness to practise history. Ms Huxtable submitted that the weight to attach to personal mitigation such as [redacted] was lower than would be attached to other aspects of the dishonesty. Turning to aggravating factors, Ms Huxtable submitted that it was an aggravating factor that the Registrant was a Director and Supervisor and had failed in his duties as a supervisor, as well as making his own clinical errors. Furthermore, he had falsified patient records and the misconduct was multi-faceted, with a real risk of harm to patients. She submitted that there was a pattern of reprehensible behaviour running through the Registrant's practice.

101. Ms Huxtable stated that the Council's position was that the appropriate sanction in this case would be erasure. She submitted that all lesser sanctions would be insufficient given the seriousness of the misconduct. Ms Huxtable described the dishonesty as deep-seated and attitudinal, which could not be addressed by conditions.

102. In relation to suspension, whilst Ms Huxtable acknowledged that the Registrant had undertaken remediation, by way of targeted CPD and reflection, she submitted that intrinsic dishonesty was not easy to remedy and there was a tangible risk of repetition. Ms Huxtable submitted that suspension would not be an adequate sanction to maintain standards and confidence in the profession. Ms Huxtable referred the Committee to the section of the HISG that considers erasure and suggested that the criteria for erasure were met, in light of the persistent dishonesty and a risk of harm to patients. She invited the Committee to find that the misconduct was fundamentally incompatible with continued registration and as such, erasure was the appropriate and proportionate sanction.

103.Mr Hall submitted that the appropriate and proportionate sanction would be a lengthy period of suspension, which would adequately protect the public and uphold standards and confidence in the profession, especially if further remediation would be checked by a Review hearing being directed. Mr Hall submitted that erasure would be disproportionate and draconian, whereas suspension would strike the correct balance, particularly in light of the Committee's findings that the Registrant had developing insight. Suspension would also allow the Registrant, an otherwise very competent Optometrist, as shown by the positive testimonials, to return to practice, which would also be in the public interest. Mr Hall submitted that the misconduct in question was not fundamentally incompatible with continued registration and that a 12 month period of suspension was a serious order, the effect of which should not be underestimated.

104.Mr Hall submitted that whilst it was accepted that there had been a risk of harm to patients this was not a significant risk. Furthermore, that the Registrant's personal mitigation was relevant, as when considering the principle of proportionality the impact upon the Registrant was a consideration. Mr Hall submitted that the Registrant's career was his whole life and if erased he would lose his livelihood and [redacted].

105.Mr Hall disagreed with the Council's submission that the dishonesty was intrinsic, deep-seated and/or attitudinal, as that had not been explained. Furthermore, he disagreed that the Registrant being a Director or Supervisor was an aggravating factor, nor that the dishonesty could properly be described as persistent as it related to four patients. It was not for example spanning many months, as a fraudulent expense claim case might.

106.In relation to insight, Mr Hall submitted that it was accepted that the Registrant's insight was lacking as to why the dishonesty occurred but that he deserves an opportunity to continue to develop this insight, which a period of suspension would allow. He stated that the Registrant was not very good at expressing his insight orally. Since the misconduct, Mr Hall submitted that the Registrant's focus has been on trying to improve the Practice, his own clinical practice, to train and get back to supervision, rather than reflect on the causes. However, going forward, the Registrant now realises this needs to be his priority, rather than the business.

107.Mr Hall referred the Committee to the many positive testimonials which spoke highly of the Registrant and how devoted he was to the profession and the Practice. Mr Hall submitted that this was not the behaviour of someone who was fundamentally incompatible with continued registration. Mr Hall highlighted that the Registrant had worked for two years since the misconduct with no repetition of the concerns and has engaged with these proceedings, admitting the misconduct.

108. In relation to the public interest, Mr Hall submitted that an ordinary member of the public, fully informed of the facts of this case, would not require erasure to uphold public confidence in the profession. He submitted that the public understand that people make mistakes and these can be remedied, and would consider that the Registrant deserves a second chance.

109. Mr Hall submitted that the HISG suggests that suspension would be appropriate and invited the Committee to impose a lengthy period of suspension. After the legal advice was given by the Legal Adviser, which touched upon financial penalty orders, Mr Hall made further submissions that such an order could be added to a suspension to tip the balance away from erasure, if the Committee considered that appropriate. Mr Hall submitted that as the Registrant was a shareholder in the Practice, there would have been a financial benefit to seeing more patients than he should, although his conduct was not motivated by such considerations. Mr Hall submitted that the Registrant did have the means to pay such an order and estimated that the benefit may have been in the region of [redacted].

110. Ms Huxtable submitted on behalf of the Council that a financial penalty order would not be in any way appropriate in this case given the seriousness of the misconduct and that there was a danger in speculating on the figure of the benefit involved.

111. The Committee accepted the advice on the Legal Adviser regarding the approach to follow when considering sanction, which was to balance the aggravating and mitigating factors, against the public interest and work up the hierarchy of sanctions, starting with the least restrictive. Further, that the Committee had to have regard to the overarching objective and the principle of proportionality.

The Committee's findings on sanction

112. When considering the most appropriate sanction, if any, to impose in this case, the Committee had regard to all of the evidence and submissions it had heard and the HISG. The Committee also had regard to its previous findings.

113. The Committee firstly considered the aggravating and mitigating factors. In the Committee's view, the particular aggravating factors in this case are as follows:

a. the insight of the Registrant is not developed, as he has not fully reflected upon why the misconduct, in particular the dishonesty, occurred;
b. there was an abuse of trust in that the Registrant was in a senior leadership position, in that he was a store director and supervisor, with responsibility for his pre-registration trainees that he should have set a good example to.

114. The Committee considered that the following mitigating factors were present:

a. there was no evidence of actual harm to patients;
b. the Registrant has apologised, has made admissions and engaged in these proceedings;
c. the Registrant has no fitness to practise history and there has been no repetition of the conduct;
d. the many positive testimonials from fellow professionals;
e. the Registrant has shown developing insight and taken steps to remediate his clinical failings (with timely remediation starting in 2023);
f. the Registrant perceived that the company were encouraging increased output (and had previously rewarded the Registrant for high volumes of patient interactions), putting the Registrant under commercial pressure, which he was influenced by (however this should not have compromised his professional standards and obligations).

115. The Committee considered the personal mitigation advanced in this case and the positive testimonials from the Registrant's professional colleagues. Whilst the Committee had previously indicated that it had given little weight at the impairment stage to the testimonials of current pre-registration Optometrists, due to a potential power imbalance, the Registrant had now provided testimonials from a wider group of colleagues, including his co-directors in the Practice, who continue to support him.

116. In relation to the Registrant's personal mitigation, the Committee considered that this had less weight than the particular features of the dishonesty, which impact upon the public interest. The Committee noted that the dishonesty related to false entries being recorded in patient records, such as recording examinations that had not been performed. The Committee considered it significant that these concerns were identified on each of the four mystery shopper interactions with the Registrant. Furthermore, that it was relevant that the investigation was instigated due to the concern that the Registrant was performing much higher than benchmark patient interactions and the profits of the store were higher than the group average. The Committee considered that the dishonesty was rooted in the Registrant's then pattern of behaviour and usual practice, although accepted that the Registrant had started to take steps to address these issues, including changing his practice since his return to work following suspension by Specsavers in 2023, taking longer to examine patients and increasing the level of supervision.

117. The Committee next considered the sanctions available to it from the least restrictive to the most severe, starting with no further action.

118. The Committee firstly considered taking no further action as set out in paragraphs 21.3 to 21.8 of the HISG. The Committee noted that exceptional

circumstances would be required and none were present in this case. Additionally, taking no action would be wholly insufficient to address the public interest concerns in this case given the seriousness of the misconduct.

119. The Committee considered the imposition of a financial penalty order. It noted that this was available as a sanction, either on its own or in addition to any other order. The Committee considered the submissions of the parties on this issue and the suggestion from Mr Hall that this could be appropriate in this case, in addition to a period of suspension. The Committee considered that on its own a financial penalty order would not reflect the seriousness of the misconduct and appropriately mark the breach of standards expected of an Optometrist in these circumstances. In relation to it being imposed alongside another order, the Committee considered that this was not a clear case for such an order, as the Allegation was not one of fraud and any financial benefit was indirect and unquantified. The Committee therefore considered that it would be difficult to identify an appropriate figure for such an order to be made.

120. The Committee next considered conditions. The Committee was of the view that conditional registration would not be practicable due to the nature of the misconduct, which involved dishonesty. In addition, the Committee was of the view that conditions would not sufficiently mark the serious nature of the Registrant's misconduct or address the public interest concerns identified. The Committee therefore concluded that conditions could not be devised which would be appropriate, proportionate, workable or measurable in this case.

121. The Committee next considered suspension and had regard to paragraphs 21.29 to 21.31 of the Guidance. In particular, the Committee considered the list of factors contained within paragraph 21.29, that indicate that a suspension may be appropriate, which are as follows:

> ***Suspension (maximum 12 months)***
>
> *21.29 This sanction may be appropriate when some, or all, of the following factors are apparent (this list is not exhaustive):*
>
> *a. A serious instance of misconduct where a lesser sanction is not sufficient.*
> *b. No evidence of harmful deep-seated personality or attitudinal problems.*
> *c. No evidence of repetition of behaviour since incident.*
> *d. The Committee is satisfied the registrant has insight and does not pose a significant risk of repeating behaviour.*

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

122. The Committee was of the view that factors a), c) and d) listed in paragraph 21.29 were applicable, with factor e) not being relevant in this case. In relation to factor a), this was a serious matter, where a lesser sanction was not sufficient, as set out above. In relation to b), the Committee did consider that the pattern and underlying context of the misconduct could be seen to indicate attitudinal problems, but looking forward, considered that this was counterbalanced by the work that the Registrant has done since to change his practice, as shown by the positive testimonials. In relation to c), there was no evidence of repetition of the behaviour since the incidents. In relation to d), the Committee had earlier found that the Registrant has developing insight and whilst there remains a risk of repetition it would not describe the risk of repetition as being significant. The Committee was therefore satisfied that there were several factors indicating that suspension may be appropriate in this case.

123. However, the Committee was mindful that the sanction it imposed had to be sufficient to protect the public, including addressing the public interest concerns. It considered that this was a finely balanced case, given the serious misconduct that it had found and went on to consider erasure.

124. The Committee was of the view that several of the factors listed in the Guidance at paragraph 21.35 (a)-(h), which lead towards the sanction of erasure being appropriate, applied in this case. Paragraph 21.35 states as follows:

Erasure

21.35 Erasure is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional and involves any of the following (this list is not exhaustive):

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 seriousness of actions or consequences.

125. The Committee were of the view that factors a), b) c) and f) were of relevance in this case. The Committee was mindful that erasure is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional. The Committee considered that the misconduct was particularly serious and at the upper end of the scale.

126. The Committee balanced the mitigating and aggravating factors in the case and considered the principle of proportionality, including the impact of an order upon the Registrant, albeit noting that this was a secondary consideration to protecting the public.

127. After careful consideration, the Committee concluded that the conduct was not fundamentally incompatible with continued registration. Although some of the factors in paragraph 21.35 of HISG were present, the Committee was of the view that erasure was not the only order that would satisfy public interest concerns and it would be disproportionate and unnecessarily punitive in this case, in light of the mitigating factors, particularly the remediation that the Registrant had undertaken, his positive testimonials and his developing insight.

128. The Committee was of the view that a lengthy suspension order was an appropriate and proportionate sanction to address the public interest concerns that it had identified. It considered that a lengthy suspension order was a serious sanction that would adequately mark the seriousness of the Registrant's conduct, maintain confidence in the profession and declare and uphold proper standards of professional conduct and behaviour. The Committee considered that a lengthy suspension would send the signal to the public and the profession that such conduct was totally unacceptable, but would also allow the Registrant the opportunity to continue to develop his insight and complete his remediation.

129. The Committee gave consideration to the appropriate length of the order of suspension. It determined that, having balanced the mitigating and aggravating factors against the public interest, it would be proportionate and appropriate to suspend the Registrant for a period of 12 months. When considering the appropriate length of order, the Committee had regard to the mitigation, the testimonials, and the impact upon the Registrant. However, the Committee also had regard to the multi-faceted nature of the misconduct, the nature of the dishonesty and the need to adequately meet the public interest. In the circumstances, the Committee was of the view that 12 months was an

appropriate and proportionate period of suspension to sufficiently mark the seriousness of the Registrant's misconduct and to address the public interest concerns it had identified.

Review hearing

130. The Committee considered whether to direct that a review hearing should take place before the end of the period of suspension. The Committee noted that at paragraph 21.32 of the Guidance, it states that a review should normally be directed before an order of suspension is lifted, because the Committee will need to be reassured that the registrant is fit to resume unrestricted practice. The Committee was mindful of its findings at the impairment stage, relating to the Registrant's developing insight, that he had not yet fully remediated and that there remained some risk of repetition. Furthermore, the Committee noted that imposing a suspension, rather than erasure, had been a finely balanced decision and one of the factors favouring suspension was to give the Registrant the opportunity to develop his insight further. Whether this has occurred can be assessed in a review hearing and if no further insight has developed, the review Committee will consider what is the appropriate and proportionate order to make at that stage.

131. In the circumstances, the Committee considered that it was necessary and appropriate for a review hearing to be directed before the order of suspension expired. The Committee considered that the Review Committee may be assisted by:

- An in-depth reflective statement demonstrating wider reflections and insight into the motivations and/or causes that led to the misconduct occurring;
- Any further evidence of remediation, such as further CPD, self-directed learning or peer review training, shadowing or mentoring.

132. The Committee therefore imposed a suspension order for a period of 12 months, with a review hearing.

133. A review hearing will be held between four and six weeks prior to the expiration of this order. The Review Committee will need to be satisfied that the Registrant:

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

Immediate order

134. The Committee heard submissions from Ms Huxtable, on behalf of the Council, regarding the imposition of an immediate order. Ms Huxtable invited the Committee to exercise its discretion to impose an immediate suspension order under Section 13I of the Opticians Act 1989 given the risk of harm to the public.

135. Mr Hall, on behalf of the Registrant, submitted that an immediate order was not necessary. He reminded the Committee that the effect of an immediate order would be to add a further month to the period of suspension, so that it would be for 13 months. As the Registrant had been practising for the past two years without restriction, an immediate order was not necessary and the Registrant could use the 28 day appeal period to put his practice in order. Mr Hall indicated that it was highly unlikely that the Registrant would appeal which was the usual concern when making an immediate order.

136. The Committee was mindful that to make an immediate order, it must be satisfied that 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.

137. The Committee bore in mind that it had found that the misconduct was serious and had concluded that a lengthy period of suspension was the appropriate and proportionate sanction in this case. In the circumstances, and given the serious nature of the misconduct, the Committee decided that it was in the wider public interest that an immediate order be imposed and a member of the public would be concerned if one were not.

138. Accordingly, the Committee imposed an immediate order of suspension.

Revocation of interim order

139. There was no interim order to revoke.

Chair of the Committee: Gerry Wareham

Signature  **Date:** 16 October 2025

Registrant: Jamil Nanda

Signature *Present remotely and received via email* **Date:** 16 October 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 Level 29, One Canada Square, London, E14 5AA or by telephone, on 020 7580 3898.