BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(24)04

AND

ATEEQ ASHRAF (01-28601)

DETERMINATION OF A SUBSTANTIVE HEARING
5-12 AUGUST 2024

Committee Members:	Mr Graham White (Chair) Mr Mark Richards (Lay) Ms Vivienne Geary (Lay) Mr Amit Jinabhai (Optometrist) Ms Sanna Nasrullah (Optometrist)
Legal adviser:	Ms Aaminah Khan
GOC Presenting Officer:	Mr Paul Renteurs
Registrant present/represented:	Yes and represented
Registrant representative:	Ms Rebecca Vanstone
Hearings Officer:	Ms Humera Asif
Facts found proved:	Allegation admitted and found proved in its entirety
Facts not found proved:	Not Applicable
Misconduct:	Found
Impairment:	Impaired
Sanction:	Conditions for a period of 2 years (With Review)
Immediate order:	Imposed

ALLEGATION

The Council alleges that in relation to you, Mr Ateeq Ashraf (01-28601), a registered Optometrist, whilst you were working for Specsavers Practice A and Specsavers Practice B:

1) Between 20 July 2019 and 21 September 2019 (inclusive), you completed eye examinations in less than 12 minutes for:

a. one or more patients listed in Schedule A, namely:

i. Patient A1,

ii. Patient A2,

iii. Patient A3,

iv. Patient A4,

v. Patient A5,

vi. Patient A6,

vii. Patient A7,

viii. Patient A8,

ix. Patient A10,

x. Patient A11,

xi. Patient A12,

xii. Patient A13,

xiii. Patient A14,

xiv. Patient A15,

xv. Patient A16,

xvi. Patient A17,

xvii. Patient A18,

xviii. Patient A19,

xix. Patient A20,

xx. Patient A21,

xxi. Patient A22,

xxii. Patient A23,

xxiii. Patient A24,

xxiv. Patient A27,

b. one or more of the patients listed in Schedule B, namely:

i. Patient B1,

ii. Patient B3,

iii. Patient B4,

iv. Patient B5,
v. Patient B6,
vi. Patient B7,
vii. Patient B8,
viii. Patient B9,
ix. Patient B10,
x. Patient B11,
xi. Patient B13,
xii. Patient B15,
xiii. Patient B16,
xiv. Patient B17,
c. one or more of the patients listed in Schedule C, namely:
i. Patient C5,
ii. Patient C19,
iii. Patient C21,
iv. Patient C22,
d. one or more of the patients listed in Schedule D, namely:
i. Patient D3,
ii. Patient D7,
iii. Patient D11,
iv. Patient D13,
v. Patient D16,
vi. Patient D18;

2) You failed to allow sufficient time to conduct adequate and/or complete examinations on some or all of the patients listed in paragraph 1(a) and/or 1(b) and/or 1(c) and/or 1(d);

3) The eye examinations you conducted for some or all of the patients listed in paragraph 1(a) and/or 1(b) and/or 1(c) and/or 1(d) were incomplete and/or performed to an inadequate standard;

4) On 20 July 2019, you failed to reach an adequate standard in performing and/or recording eye examinations in relation to one or more of the patients below, in that you failed to undertake and / or record:
a. visual fields for Patient A4,

b. in relation to Patient A12:
i. measurements of intraocular pressure,
ii. visual fields,
c. visual fields for Patient A18;

5) On 27 July 2019, you failed to reach an adequate standard in performing and/or recording eye examinations in relation to one or more of the patients below, in that you failed to undertake and / or record:
a. the measurement of intraocular pressure in relation to Patient B8,
b. visual fields in relation to Patient B6;

6) On 14 September 2019, you failed to reach an adequate standard in performing and/or recording eye examinations in relation to one or more of the patients below, in that you failed to undertake and/or record:
a. measurement of the intraocular pressure in relation to Patient C2,
b. measurement of the intraocular pressure in relation to Patient C9;

7) Between 20 July 2019 and 21 September 2019 you failed to adequately undertake the measurement of and / or accurately record the measurement of basic binocular vision in relation to:
a. one or more of the patients listed in Schedule A,
b. one or more of the patients listed in Schedule B,
c. one or more of the following patients in Schedule C:
i. C1,
ii. C2,
iii. C3,
iv. C4,
v. C5,
vi. C6,
vii. C7,
viii. C10,
ix. C11,
x. C12,
xi. C13
xii. C14,
xiii. C15,

xiv. C18,

xv. C19,

xvi. C20,

xvii. C21,

xviii. C22,

xix. C23,

d. one or more of the patients listed in Schedule D;

8) Between 20 July 2019 and 21 September 2019 on more than one occasion you failed to keep patient-tailored records in that you used the same entries across multiple records, including but not limited to:

a. cover testing,

b. pupil reactions,

c. internal eye examinations,

d. flashes and floaters,

e. symptoms,

f. reasons for visit.

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

[For schedules see Annex]

DETERMINATION

Preliminary Issues

1. Prior to the hearing commencing, an Optometrist member of the Committee, Mr Amit Jinabhai, raised that he had a professional connection, albeit tenuous, with the expert witness in the case, Professor Harper, in that they had both worked for Manchester University. However, they were in different roles and did not work together. Both parties were informed of this issue prior to the hearing, and both confirmed that they were content with Mr Jinabhai continuing to sit on this case. The Committee was satisfied in the circumstances that this did not give rise to bias and continued as originally constituted.

Admissions in relation to the particulars of the allegation

2. The Registrant admitted the allegation in its entirety. Where a particular was framed in the alternative, the Registrant admitted it on the basis that 'and' rather than 'or' applied. For example, in particular 4, the Registrant admitted both the

failure to undertake aspects of the examination in question and to record them. Where a particular related to more than one patient (see for example particular 7(a)), the Registrant admitted it on the basis that the conduct applied to more than one patient listed.

3. The entire facts were announced by the Chair as found proved following the Registrant's admissions, pursuant to Rule 46(6) of the General Optical Council (Fitness to Practise) Rules Order of Council 2013 ("the Rules").

Background

4. The Registrant is an Optometrist, who registered in March 2015. At the time of the events set out in the Allegation, the Registrant was working in two branches of Specsavers in *[redacted]*, Practice A and Practice B.

5. It is alleged, in summary, that the Registrant took insufficient time to perform eye examinations on a number of patients, seen on four dates between 20 July 2019 and 21 September 2019. The Council's case is that for example, a routine eye examination should take in the region of 20 - 30 minutes, whereas for the patients listed, the Registrant completed their eye examinations in less than 12 minutes.

6. Following an audit and the instruction of an expert witness, Professor Harper, concerns were raised in respect of over 80 patients that the Registrant had examined on the four dates in question. The concerns in essence are that a number of the examinations were inadequate and/or incomplete, as set out in the Allegation, and the Registrant's record keeping was deficient.

Findings in relation to misconduct

7. Having found all of the alleged facts proved, the Committee proceeded to the next stage, which was to consider whether they amounted to misconduct, which was serious.

8. The Committee heard submissions from Mr Renteurs, on behalf of the Council, and from Ms Vanstone, on behalf of the Registrant.

9. Mr Renteurs submitted that the admitted facts amounted to misconduct and in particular, serious misconduct. Whilst there was no statutory definition of misconduct, he referred to the description given by Lord Clyde in the case of *Roylance v GMC* [2000] 1 AC 311, that it was a word of general effect and was some act or omission falling short of the standards of practice to be expected. The use of the word deplorable had been used previously, however more recent case law had considered that this language did not assist and was better not used. Whether conduct amounts to misconduct, which was serious, is a decision entirely for the Committee.

10. Mr Renteurs referred the Committee to the expert evidence and the range of opinion of Professor Harper, who had identified some of the Registrant's conduct as falling far below the required standard and some falling below, but not far below. Mr Renteurs submitted that the conduct that fell below, but not far below, needed to be seen in the context of the Registrant's other failings. Furthermore, Professor Harper was making those observations based upon his clinical opinion; whether it was appropriate to cumulate them into serious misconduct was solely a matter for the Committee.

11. Mr Renteurs invited the Committee to consider particulars 4 to 6 of the Allegation on a cumulative basis. These related to specific identifiable instances in respect of specific patients, where the examinations were demonstrably not adequately carried out by the Registrant. These could be contrasted with other parts of the Allegation (particulars 1 to 3 and 7 to 8), which were of a different and more general type, where it was not possible to say how completing the eye examinations in less than 12 minutes would affect the adequacy. Taking the 48 patients in the round, it was likely that there would be inadequacies across the patient cohort.

12. Mr Renteurs submitted that in this case, it was correct as a matter of law to cumulate the parts of the Allegation which was mere misconduct into a finding of serious misconduct. Mr Renteurs referred the Committee to the cases of *Schodlok v GMC* [2015] EWCA Civ 769 and *Ahmedsowida v The General Medical Council* [2021] EWHC 3466 (Admin), which he summarised. Mr Renteurs submitted that the circumstances of this case were very different to the facts of *Schodlok* and *Ahmedsowida* (where cumulation was criticised) and there were a large number of patients here (48), which was just over 50% of the patients examined by the Registrant on those four days.

13. Mr Renteurs invited the Committee to consider the large number of patients in respect of whom generic entries had been made in their records by the Registrant, the large number of non-serious misconduct issues, plus the context of the specific failings in particulars 4 to 6. Mr Renteurs submitted that it was entirely proper to conclude that particulars 4 to 6 of the Allegation could be considered, taken together, to constitute serious misconduct.

14. Ms Vanstone, on behalf of the Registrant, accepted that the facts found proved amounted to misconduct. She acknowledged that whilst the Registrant accepted misconduct, whether it was found was a matter for the Committee. Ms Vanstone agreed with Mr Renteurs' submission that although Professor Harper had given his opinion on cumulating non-serious misconduct into serious misconduct, this was a question of law for the Committee. Ms Vanstone had no further submissions to make on the issue of cumulation, as it was a legal matter for the Committee to decide considering the applicable legal principles and legal advice to be given by the Legal Adviser.

15. Ms Vanstone noted that Professor Harper was available to give evidence if the Committee wished to hear from him. She submitted that there could be potential

unfairness in calling Professor Harper at this stage, as the Registrant had made his admissions and accepted misconduct based upon the reports of Professor Harper, as they stood. However, she acknowledged that this was a matter for the Committee.

16. The Committee noted that Professor Harper was available to give evidence if required, however this was not considered necessary given that the Registrant had made admissions to the Allegation in its entirety, based upon the reports of Professor Harper, which were not contested.

17. The Committee heard and accepted the advice of the Legal Adviser. The Committee was reminded 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.

18. This threshold of serious misconduct has been described in the case of *Meadow v GMC* [2006] as being conduct which would be regarded as deplorable by fellow practitioners. However, it does not necessarily require moral turpitude; an elementary and grievous failure can also reach the threshold of serious misconduct, as can conduct that would be regarded as negligent, if sufficiently serious (as per *Calhaem, R (on the application of) v General Medical Council* [2007] EWHC 2606 (Admin)).

19. The Legal Adviser gave advice on the issue of whether it was permissible for the Committee to take a cumulative approach to finding serious misconduct, given that the expert evidence of Professor Harper was that some of the Registrant's failings fell below, but not seriously below, the standards expected.

20. The Legal Adviser also referred the Committee to the case of *Schodlok v GMC* [2015] EWCA Civ 769, which suggests that it may be permissible, in an appropriate but rare case, for a tribunal to undertake the exercise of cumulating findings of misconduct on some charges to make a determination of serious misconduct on others. However, the more recent case of *Ahmedsowida v The General Medical Council* [2021] EWHC 3466 (Admin), stated that in relation to cumulation for a finding of serious misconduct,

> *"If that is permissible at all, the exercise is supposed to involve the cumulation of non- serious with other non-serious misconduct findings; not of one non-serious misconduct finding with another finding(s) of misconduct that is serious in its own right. In the latter context, there is no good reason to cumulate; the quality of the conduct is already correctly expressed, without the need for any cumulation."*

21. The Legal Adviser advised that based upon these authorities, it was open to the Committee for a cumulative approach to be taken in an appropriate case, in the limited circumstances suggested in *Ahmedsowida.* However, these authorities

would need to be carefully considered and there ought to be a large number of failings, of a similar nature, which were all not serious misconduct, rather than cumulating a mixture of serious and non-serious misconduct.

22. The Committee considered the "*Council's Standards of Practice for Optometrists and Dispensing Opticians*," effective from April 2016. The Committee was of the view that the Registrant has departed from the following standards by virtue of his conduct:

    • *Standard 7: Conduct appropriate assessments, examinations, treatments and referrals;*

    • *Standard 8: Maintain adequate patient records.*

23. The Committee was satisfied that there were failings by the Registrant in this case both in respect of recordkeeping and clinical failings in relation to the assessment, examination, and/or management of patients. In respect of both standards 7 and 8, the conduct of the Registrant, as found proved, had fallen below the expected standards of what was proper in the circumstances.

24. The Committee was mindful that not every falling short of the standards was sufficient to amount to misconduct, as it must be serious. The Committee went on to consider whether the Registrant's failures were serious, considering each particular in the Allegation. The Committee had regard to the expert evidence in the case of Professor Harper.

25. The Committee considered that the facts that had been admitted by the Registrant demonstrated a pattern of behaviour, which had been found from an analysis of his patients' records from four days of his practice, between 20 July 2019 and 21 September 2019. The failings did not arise in a small number of isolated incidents, but rather from a large patient cohort. The Committee considered that there was a range of alarming failings, which demonstrated grossly irresponsible conduct.

26. The Committee noted that the Registrant had made full admissions and had accepted that his failings were not limited to failing to record matters, but that he had also not undertaken adequate examinations. The Committee noted that on the first date in question, the 20 July 2019, the Registrant had seen a large number of patients, so that he may have been under time pressure, however that was not the case for each date in question.

27. The Committee noted that Professor Harper had found that in respect of many aspects of the Registrant's conduct it fell far below the standards to be expected of a reasonably competent Optometrist. In relation to particulars 1, 2 and 3, the Committee found that this conduct was closely linked and was clearly misconduct, which was serious. Similarly, in respect of particulars 7 and 8, failing to adequately measure and record basic binocular vision and failing to keep tailored records, duplicating entries across multiple patient records, Professor Harper considered that this was conduct which fell far below the standards to be expected of a reasonably competent Optometrist.

28. The Committee accepted the expert evidence of Professor Harper, as to his assessment of the seriousness of the Registrant's failings.

29. The Committee considered particulars 4 to 6, in which Professor Harper had found that the Registrant's failings, when looked at individually, were below but not far below, the standards to be expected. The Committee considered the issue of

cumulation, as invited to do so by the Council, and whether it could amount to misconduct, which was serious, when taken together with the other similar conduct, particularly when considered against the wider context of the case.

30. The Committee was mindful of the case of *Ahmedsowida v GMC,* and the earlier case of *Schodlok v GMC [2015] EWCA Civ 769* and the Legal Advice it had received, as set out above. In the circumstances of this case, the Committee was satisfied that it was appropriate to take a cumulative approach to the Registrant's conduct in particulars 4 to 6 and to find that this also amounts to misconduct that was serious. Whilst this would not be the case when the individual conduct was looked at in insolation, the Committee was of the view that the conduct in this case was intertwined and had to be looked at in the round.

31. The Committee accepted the clinical view of Professor Harper that when looked at in the wider context of the case, these failings did fall far below the standards to be expected. The Committee was mindful that regardless of Professor Harper's view, the issue of cumulation was a legal issue for its own decision making. Nonetheless, it was satisfied, having considered the parties submissions, the legal authorities and legal advice received, that this was a proper and appropriate case to take the cumulative approach, given the range of patients affected and the similarity of the concerns.

32. The Committee was therefore satisfied that in relation to the entire Allegation, the Registrant's conduct fell far below the standards to be expected of a reasonably competent Optometrist and was serious.

33. Accordingly, the Committee found that the admitted facts amount to misconduct, which was serious.

Impairment

34. The Committee went on to consider whether the fitness to practise of the Registrant was currently impaired, as a result of the misconduct found.

35. The Committee received a bundle of documents on behalf of the Registrant relevant to the issue of impairment, which included clinical statistical reports from Specsavers, CET and CPD statements, references from four professional colleagues, audit reports and a newspaper article dated 17 December 2020, regarding the Registrant's detection of a patient's tumour. It also received a witness statement of the Registrant, containing his reflections upon the misconduct.

36. Having read the Registrant's bundle and witness statement, the Chair of the Committee indicated that although it was a matter for the Registrant whether or not he gave evidence at this stage of the proceedings, and it would not be held against the Registrant if he chose not to do so, there were matters arising from the documents that the Committee would wish to ask the Registrant about. Ms Vanstone took instructions from the Registrant and subsequently confirmed that he did not wish to give oral evidence to the Committee.

37. The Committee heard submissions from Mr Renteurs, on behalf of the Council and from Ms Vanstone, on behalf of the Registrant.

38. Mr Renteurs reminded the Committee that the focus when determining impairment was forward looking, rather than as in misconduct, which was looking backwards. He highlighted that the issue was whether the Registrant's fitness to practise remains impaired as of today and acknowledged that it was now five years on from the misconduct. However, Mr Renteurs submitted that the nature and gravity of the misconduct was not irrelevant and one of the crucial aspects for the Committee to consider was its impact upon the reputation of the profession.

39. Mr Renteurs invited the Committee to consider what would a reasonable, well informed, member of the public think about the Registrant returning to practise without restrictions. Mr Renteurs referred the Committee to the guidance of Mr Justice Silber, in *Cohen v General Medical Council* [2008] EWHC 581 (Admin), that any approach to impairment must take account of the need to protect the patient, as well as the need to maintain confidence in the profession and to declare and uphold proper standards of conduct and behaviour. Furthermore, it was stressed in *Cohen* that impairment and misconduct are separate stages, and a finding of misconduct does not automatically lead to a finding of impairment. Mr Renteurs highlighted that in *Cohen,* it was stated that,

> "*There must always be situations in which a Panel can properly conclude that the act of misconduct was an isolated error….and the chance of it being repeated in future is so remote that his or her fitness to practice has not been impaired*."

40. Mr Renteurs submitted that the reference to an isolated incident did not apply to the Registrant, given that the Committee had found that his misconduct was a pattern of behaviour, concerning a large number of patients. Mr Renteurs added that this was over a significant period of time.

41. Mr Renteurs referred the Committee to the guidance in the case of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (admin) and the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry. Mr Renteurs submitted that limbs (a)-(c) of this test are engaged in this case, namely conduct which put patients at unwarranted risk of harm, brings the profession into disrepute, and which breaches one of the fundamental tenets of the profession.

42. Mr Renteurs submitted that whilst there was no evidence of actual harm to patients, it was obvious that if the Registrant consistently performed inadequate examinations, in insufficient time, there was an inherent risk of harm, as at some point something would be missed. Mr Renteurs submitted that the Registrant had plainly brought the profession into disrepute by a pattern of misconduct. A member of the public would be deeply troubled by the misconduct in this case. In relation to breaching a fundamental tenet of the profession, Mr Renteurs referred the Committee to the following section of "*Council's Standards of Practice for Optometrists and Dispensing Opticians*," effective from April 2016,

> *"**1. Listen to patients and ensure they are at the heart of the decisions made about their care***
>
> *1.1 Give patients your full attention and allow sufficient time to deal properly with their needs."*

43. Mr Renteurs submitted that this was a fundamental tenet, and the fact that it was the first principle listed in the Standards underlined the importance of it.

44. Mr Renteurs invited the Committee, when considering the risk of repetition, to consider the material provided by the Registrant regarding the CPD and remediation undertaken, his otherwise wholly unblemished record and his positive testimonials. It was a matter for the Committee how it reconciled the positive testimonials with the misconduct in this case.

45. Mr Renteurs argued that insight was different from remorse. In relation to insight, Mr Renteurs acknowledged that the Registrant may have shown contrition in his witness statement, but he submitted that insight goes further and requires the demonstration of a real understanding of not only what had been done but the reasons why and the motivations giving rise to the behaviour in question. Apart from a brief reference to being a busy practice, Mr Renteurs submitted that the Registrant's witness statement was lacking in this regard and there was little explanation as to how being busy led to falling so short of the standards expected.

46. In concluding, Mr Renteurs submitted that the Registrant's current fitness to practise was clearly impaired, given the seriousness of the misconduct, concerning a large number of patients, over a significant period and the causes had not been grappled with by the Registrant.

47. Ms Vanstone submitted that there was no continuing risk to patients which required a finding of impairment on public protection grounds. Furthermore, a finding of impairment was not necessary on public interest grounds, when all of the relevant factors are looked at and properly considered.

48. In relation to public protection, Ms Vanstone stated that the Registrant recognised the seriousness of the concerns, he had made admissions to all of the facts and did not challenge a finding of misconduct. Ms Vanstone submitted that the time period since the misconduct, of five years, was extremely significant in this case. Ms Vanstone stated that the Council's description of the conduct as being a pattern of behaviour over a significant time period was not accepted by the Registrant, as the Allegation was based upon four days of his practice between July and September 2019.

49. Ms Vanstone highlighted that in the five years since the misconduct the Registrant has worked entirely unrestricted, with no repetition of the conduct. He has no prior fitness to practise history and no other complaints. The four days in question are a small period of time in the context of a long unblemished career.

50. Ms Vanstone reminded the Committee to consider the three factors arising from the case of *Cohen*, namely, whether the conduct was capable of remediation, whether it had been remedied and the risk of repetition. In relation to the first factor, Ms Vanstone submitted that the misconduct in this case, of clinical issues and record-keeping, was clearly capable of remediation.

51. In relation to whether it had been remedied by the Registrant, Ms Vanstone submitted that the Committee can be satisfied that it has so that there is no longer any risk to the public. She referred the Committee to the CPD that the Registrant had undertaken, including on the topics of record-keeping, the management of glaucoma and visual field testing, all of which were relevant to the misconduct.

52. Ms Vanstone submitted that the Registrant had reflected over the long period of this investigation and improved his standards of practice. She referred to the Specsavers clinical outcome reports that had been put before the Committee, which showed that the Registrant's average test times were just under seventeen minutes over eight months. In addition, the Registrant's percentage of referrals and visual field testing were above average. In relation to the misconduct found,

the average testing time across 48 patients was 7.5 minutes, therefore there had been a very significant change. Ms Vanstone reminded the Committee of the evidence of Professor Harper that the length of an examination was a matter of professional judgement and there is likely to be a range of what was typical.

53. Ms Vanstone referred to the Committee's comments in the misconduct determination regarding the Registrant examining a large number of patients on the first date only, which was not the case. Ms Vanstone stated that the Registrant had seen more patients than referred to in the Allegation and had seen 27, 17, 24 and 20 on the four dates respectively, which were high numbers of patients in a busy City centre practice.

54. Ms Vanstone took the Committee through the audits that had been placed before it of the Registrant's practice. Ms Vanstone submitted that the comments made by the assessor Mr A in his May 2023 audit related to the Registrant's advice to patients being brief and there were multiple references to the Registrant carrying out all appropriate examinations. Ms Vanstone submitted that any comments regarding the Registrant's record-keeping would not be sufficient to amount to misconduct on their own and were not sufficient to show an ongoing risk to the public.

55. Ms Vanstone highlighted the Registrant's evidence in his witness statement regarding working with Mr A and spending more time on his practice. There had been a more recent NHS audit carried out, which she acknowledged was not perfect. However, the Registrant did not have to put this before the Committee and did so to be candid. When considering this audit, Ms Vanstone submitted that 200 criteria were assessed and the concerns raised related only to 1%. Ms Vanstone submitted that whilst there may be some further work for the Registrant to do, this would not be sufficient to show any ongoing risk to the public or risk of repetition.

56. Furthermore, Ms Vanstone referred to the expert evidence of Professor Harper and his view that when looking at a large set of records, no registrant records would be error free. In addition, he referred to record-keeping issues as being sub-optimal, rather than falling below or far below the standards to be expected. In total thirty records of the Registrant had been assessed by Mr A and in the NHS audit, which Ms Vanstone submitted painted a proper picture of the Registrant's practice. The audits raised record-keeping issues rather than clinical performance. Ms Vanstone invited the Committee to find that the concerns in this case had been remediated by the Registrant and they were highly unlikely to reoccur.

57. Ms Vanstone submitted that the Registrant realises the importance of reflection and had taken a resident post, despite this resulting in a reduction in income, which showed a commitment to patient care and self improvement. Furthermore, she submitted that the fact that the Registrant had worked entirely unrestricted since the misconduct shows that he is of no risk to the public.

58. In conclusion, Ms Vanstone invited the Committee to find that the Registrant was not currently impaired on public protection grounds. In relation to the wider public interest, she submitted that a reasonable, well informed, observer would know that the misconduct occurred over only four days, five years ago, that the Registrant admitted all of the Allegation, and had worked entirely unrestricted since then. Further, there had been no other complaints or repetition. Ms Vanstone submitted that being aware of the above matters, a member of the

public would not consider it necessary for there to be a finding of impairment on wider public interest grounds.

59. Ms Vanstone reminded the Committee that the Registrant had apologised to the Council and the profession, which she submitted shows insight and appreciation of the impact of the misconduct on the profession. She submitted that the Council's role and reputation was maintained by bringing these proceedings and the finding of misconduct against the Registrant.

60. Ms Vanstone stated that in the case of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (admin), the Nursing and Midwifery Council did not have the power to impose a warning, which was relevant to the public interest considerations. Ms Vanstone reminded the Committee that if it agreed that the Registrant was not impaired, it could consider a warning, which she submitted would be a proportionate and sufficient response.

61. The Committee heard and 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. She outlined the relevant principles set out in the case of *Cohen v GMC* [2008] EWHC 581 (Admin), namely that the Committee ought to consider whether the misconduct is remediable, has been remedied and the risk of repetition.

62. The Legal Adviser referred the Committee to the test for considering impairment as set out by Dame Janet Smith in the fifth report of the Shipman Inquiry (para 25.67), and cited with approval in the case of *CHRE v NMC & Paula Grant* [2011] EWHC 927 (Admin), para 76, by Mrs Justice Cox, which is:

> *"Do our findings of fact in respect of the…misconduct, show that his fitness to practise is impaired in the sense that he:*
>
> *(a) Has in the past acted and/or is liable in the future to so act so as to put a patient or patients at unwarranted risk of harm and/or;*
> *(b) Has in the past brought and/or is liable in future to bring the medical profession into disrepute and/or;*
> *(c) Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession and/or;*
> *(d) ….."*

The Committee's findings on impairment

63. In making its findings on current impairment, the Committee had regard to the evidence it had received to date, the submissions made by the parties, the Hearings and Indicative Sanctions Guidance (revised November 2021) ('the Guidance'), the Council's Standards of Practice, the legal advice given by the Legal Adviser and its earlier findings.

64. The Committee firstly considered whether the Registrant's conduct was remediable, whether it had been remedied and whether the conduct is likely to be repeated in future.

65. The Committee noted that the misconduct in this case concerned clinical issues relating to the assessment and management of patients, including record-keeping concerns. The Committee was of the view that the nature of the misconduct in this case was such that it was easily remediable.

66. In relation to whether the misconduct had been remedied by the Registrant since the date of the misconduct, which occurred in 2019. The Committee considered the steps that the Registrant has taken in order to remediate, which include the reflection in his witness statement, the relevant Continuing Professional Development ('CPD') undertaken, and the various audits reports of his clinical practice. The Committee noted that only one of the NHS audits had been produced by the Registrant, even though the Registrant confirmed that there had been several.

67. The Committee had regard to the fact that the Registrant has undertaken some relevant CPD, however it considered that there was no evidence of what the Registrant had learnt from this CPD and how he had implemented any learning from it into his practice. The Committee noted that the Registrant referred in his statement to how he intended to draft a full Personal Development Plan ('PDP'), regardless of the outcome of these proceedings. However, a copy of the Registrant's PDP was not placed before the Committee.

68. The Committee considered the submission of Ms Vanstone that the Registrant has increased his average testing times from 7.5 minutes per patient in respect of those included in the Allegation, to between 16 and 17 minutes. However, the Committee was of the view that, as this was a mean figure only, there would be a range of testing times, with some below that time. It was also not known what the upper and lower ends of the range are. The Committee noted that as recently as February 2024, the Registrant's average consultation time for that month was 14.56 minutes. Furthermore, whilst there had been an increase in the average time when compared with the times concerned in the misconduct, it was still significantly lower than the 20-30 minutes that in Professor Harper's opinion could be typical for the duration of an examination. The Committee was therefore concerned that this data appeared to show that some of the original concerns are ongoing.

69. The Committee considered the level of insight demonstrated by the Registrant. It bore in mind the evidence that it had before it from the Registrant, namely his witness statement and the documentation that he had produced. The Committee did not draw any adverse inference from the Registrant not giving evidence at this stage of the proceedings. However it considered that it would have been helpful had he done so. The Committee considered that, based upon the evidence before it, the Registrant's insight into the concerns arising in this case was limited.

70. The Committee noted that the Registrant had expressed remorse, in that he had apologised, and had made admissions to the Allegation, including accepting that his actions amounted to misconduct. However, the Committee considered that the Registrant's witness statement did not show a clear understanding of why the concerns arose and what motivated the misconduct. It referred to the Registrant working in a busy practice, however the Committee did not consider that to be particularly unusual. In addition, the Registrant had not reflected upon what he could have done to ensure that, despite how busy the practice was, he gave patients the sufficient time they required to deal adequately with their individual needs.

71. The Committee was also of the view that, whilst the Registrant had apologised to the Council and the profession in his witness statement, there was no evidence that he had reflected upon the impact of his misconduct upon patients, particularly those who had not received an adequate examination and the risk to them of issues being missed. In addition, the Registrant's witness statement did not reflect upon why it was important to be careful and thorough when carrying out eye examinations.

72. The Committee therefore concluded that the Registrant still has work to do in relation to his insight and remediation in order for the Committee to be reassured that he has adequately remedied his misconduct.

73. The Committee bore in mind that the Registrant has practised as an Optometrist since 2015, with a previously unblemished career and had practised unrestricted since the misconduct occurred in 2019 without apparent repetition. However, balanced against that was the audit report evidence, which the Committee considered carefully.

74. The Committee placed particular weight upon the NHS audit, given that it was recent (31 July 2024) and was an external audit, therefore more likely to be impartial. The Committee noted that the assessor had raised some concerns, some of which were similar in nature to the issues in this case, for example in relation to visual field testing and relating to risks of glaucoma. Out of the ten sets of records reviewed, the Committee noted that four of them raised concerns. The Committee had regard to the conclusions of this audit that there was still a repetition of earlier themes, stating that,

> *"Overall record keeping reviewed today was of a fairly good standard, but a continued theme still appears to be not always discussing and then recording any discussions with patients about their sight test findings. While some cases today did show record keeping improvement from our last audit three of the four areas highlighted previously still are not being discussed and recorded at each sight test.*
>
> *<u>Conclusions</u>*
>
> *Improved record keeping since last audit but similar themes still need fully addressing.*
>
> *<u>Recommendations</u>*
>
> *A well considered and updated PDP can help with professional development planning."*

75. The Committee concluded that whilst the conduct is remediable, the Registrant has only limited insight and the misconduct has not yet been adequately remedied by the Registrant, therefore there remains a real risk of repetition. Accordingly, the Committee determined that the Registrant's fitness to practise is currently impaired on the personal component.

76. The Committee also had regard to public interest considerations and 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 Mr Renteurs that limbs (a)-(c) of this test are engaged in this case, namely conduct which put patients at unwarranted risk of harm, brings the profession into disrepute and breaches a fundamental tenet of the profession. The Committee was of the view that giving patients full attention and sufficient time to deal properly with their needs

(Standard 1.1) was a fundamental tenet of the profession. The Committee considered that these limbs of the test were engaged on past conduct in relation to misconduct found proved, and that the Registrant was also '*liable in the future*' to act in a similar manner, given the Committee's view on the Registrant's limited insight and the risk of repetition.

77. The Committee was of the view that the public would be concerned if no finding of impairment was made, given the lack of adequate remediation, the Registrant's limited insight and risk of repetition. The Committee determined that it was also 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 and conduct.

78. Accordingly, the Committee found that the fitness of the Registrant to practise as an optometrist is currently impaired.

Sanction

79. The Committee proceeded to consider what would be the appropriate and proportionate sanction, if any, to impose in this case. It heard submissions from Mr Renteurs, on behalf of the Council, and from Ms Vanstone, on behalf of the Registrant. No further evidence was placed before the Committee at this stage.

80. Mr Renteurs reminded the Committee that the proper approach to sanction was to weigh the interests of the public against the interests of the Registrant, balancing the mitigating and aggravating factors in the case.

81. Mr Renteurs submitted that the mitigating factors in the case may be the Registrant's otherwise unblemished character, and there had been no repetition since the misconduct that occurred five years ago. Furthermore, the Registrant had undertaken some targeted CPD and remediation, and his colleagues think highly of him providing supportive testimonials. Full and frank admissions were made to the Allegation and misconduct had been accepted.

82. Turning to aggravating factors, Mr Renteurs suggested that the Committee was entitled to take into account that the Registrant's insight is limited and the seriousness of the misconduct, in that it involved a large number of patients over a substantial period of time.

83. Mr Renteurs emphasised that the Committee was required to consider the least restrictive sanction first, with regard to the Guidance. The starting point was to consider taking no further action but Mr Renteurs submitted that would not be an appropriate course, as this was not an exceptional case and the Registrant had not demonstrated all of the insight and remediation that the Committee would wish to see.

84. Mr Renteurs reminded the Committee that it had the power to impose a financial penalty. However, the Guidance indicates that this is most appropriate in cases where the conduct was financially motivated or resulted in financial gain, which is not how this case had been framed by the Council.

85. Turning to conditions of practice, Mr Renteurs stated that conditions could be imposed for up to three years and the primary purpose of conditions was to protect the public. They might for example require the Registrant to undergo training. Positive requirements could be made of the Registrant in conditions and the

Guidance states that they may be most appropriate in cases concerning performance or specific shortcomings in a registrant's practice, which may be apt in this case.

86. Mr Renteurs reminded the Committee that conditions needed to be appropriate, proportionate, workable and measurable. He referred to paragraph 21.25 of the Guidance, which sets out circumstances where conditions may be appropriate and submitted and which the Committee may feel are apt to describe the circumstances.

87. Mr Renteurs stated that it was not the Council's case that a period of suspension was appropriate given that the Registrant had been practising unrestricted for the past five years. He submitted that it would be strange and difficult for the Council to argue that the public interest necessitates a suspension now, but the appropriate sanction was a matter for the Committee.

88. Mr Renteurs submitted that an immediate order would be necessitated, in light of the public interest and the serious nature of the misconduct.

89. Ms Vanstone, on behalf of the Registrant, invited the Committee when considering sanction to have regard to the time that has elapsed since the misconduct. She reminded the Committee that there had been no restrictions placed upon the Registrant in the past five years and no repetition of the conduct. The Registrant had continued to practise during this investigation with this investigation hanging over him.

90. Turning to mitigation, Ms Vanstone submitted that it was mitigation that the Registrant had made full admissions and also his efforts to remediate, albeit the Committee had found that this was incomplete. Ms Vanstone submitted that it was also conduct occurring over a short period of time in the context of a ten year otherwise unblemished career.

91. In relation to aggravating factors, Ms Vanstone submitted that no other aggravating factors, as suggested in the Guidance, applied.

92. Ms Vanstone referred the Committee to the Guidance and that the starting point was to consider taking no further action, which the Registrant acknowledged would not be an appropriate outcome in this case, given the lack of exceptional circumstances. She also agreed that a financial penalty was unlikely to be appropriate due to the nature of the misconduct.

93. Turning to conditions, Ms Vanstone submitted that conditions should be the height of the sanctions considered in this case. She submitted that conditions would be appropriate and would meet the public protection and the public interest considerations.

94. Considering the factors which indicate that conditions may be appropriate, at paragraph 21.25 of the Guidance, Ms Vanstone submitted that these squarely applied, albeit with some factors not being relevant. She submitted that there was no evidence of harmful deep-seated personality or attitudinal problems. The Committee had identified specific areas of the Registrant's practice in need of assessment or retraining. Further, the Registrant was willing to respond positively, he was willing to comply with conditions imposed and he had supportive employers.

95. Ms Vanstone submitted that patients would not be put in danger by the imposition of conditions, which was plainly demonstrated by the Registrant practising unrestricted for five years. Conditions would protect patients and, as the case

concerns clinical conduct, it was possible to formulate appropriate and practical conditions in this case.

96. Ms Vanstone submitted that the Committee was required to consider the least restrictive sanction first and anything greater than conditions would be disproportionate given the Committee's findings, the remediation that the Registrant had done to date and the time that had elapsed since the misconduct.

97. Ms Vanstone indicated that the Registrant would resist any suggestion that it was necessary for any immediate order to be made, given that the Registrant had been working unrestricted for the past five years and there had never been any interim order in place and no repetition of the misconduct. Mr Renteurs submitted that the difference now, when considering whether to impose an immediate order, was that a finding of misconduct and impairment had been made and the question was what would a reasonable, well informed, member of the public think.

98. The Committee invited the parties to make any submissions on the length of order and Mr Renteurs declined to do so, indicating that it was entirely a matter for the Committee. Ms Vanstone submitted that the duration should be the least time necessary for the Registrant to complete the remediation work required.

99. The Committee accepted the advice of the Legal Adviser, which was for the Committee to take into account the factors on sanction as set out in the Guidance; to assess the seriousness of the misconduct; to consider and balance any aggravating and mitigating factors; and to consider the range of available sanctions in ascending order of seriousness. Further, the Committee is required to act proportionately by weighing the interests of the Registrant against the public interest.

100. On the issue of an immediate order, the Legal Adviser referred the Committee to the relevant section in the Guidance and reminded it of the statutory test in section 13I of the Opticians Act 1989, 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.

The Committee's findings on sanction

101. 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, as well as its previous findings at the misconduct and impairment stages.

102. The Committee firstly considered the aggravating and mitigating factors that were present. In the Committee's view, the aggravating factors in this case are as follows:

a. The Registrant has not demonstrated the timely development of insight, nor has he provided a copy of his PDP.

103. The Committee considered that the following were mitigating factors:

a. The Registrant made full admissions to the Allegation, albeit some particulars were not admitted until the first day of the hearing;

b. The Registrant conceded that his actions amounted to misconduct;

c. The Registrant was of previous good character with no prior fitness to practise history;

d. The Registrant has undertaken some targeted CPD, for example relating to glaucoma;

e. The Registrant has developed some, albeit limited, insight.

104. The Committee considered the positive references that had been provided by the Registrant's colleagues, but gave limited weight to them given that they did not address the failings identified in this case, such as the Registrant's testing times and management of patients with suspected glaucoma, or what changes have been implemented by the Registrant since the misconduct.

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

106. The Committee considered taking no further action as set out in paragraphs 21.3 to 21.8 of the Guidance. The Committee was of the view that there were no exceptional circumstances present that could justify taking no further action in this case. It further considered that taking no further action was not proportionate, nor a sufficient outcome, given the public protection concerns in the case, and the Committee's findings on impairment.

107. The Committee next considered the issue of a financial penalty order. However, it was of the view that such an order was not appropriate, given that the Registrant's conduct was not financially motivated and had not resulted in financial gain.

108. The Committee next considered the Guidance in relation to the imposition of conditional registration. The Committee bore in mind that the primary purpose of conditions was to protect the public. It noted in particular that at paragraph 21.17 of the guidance it states,

> *"Conditions might be most appropriate in cases involving a registrant's health, performance, or where there is evidence of shortcomings in a specific area or areas of the registrant's practice."*

109. The Committee considered that this was a type of case where conditions would be appropriate, as the misconduct related to shortcomings in specific areas of the Registrant's practice, as set out in the evidence of Professor Harper. Further, it had found that the conduct was easily remediable, and it was satisfied that the Registrant was willing to remediate.

110. The Committee considered the factors in the Guidance set out at paragraph 21.25, which indicated when conditions may be appropriate:

"Conditional registration may be appropriate when most, or all, of the following factors are apparent (this list is not exhaustive):

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

b. Identifiable areas of registrant's practise in need of assessment or retraining.

c. Evidence that registrant has insight into any health problems and is prepared to agree to abide by conditions regarding medical condition, treatment, and supervision.

d. Potential and willingness to respond positively to retraining.

e. Patients will not be put in danger either directly or indirectly as a result of

conditional registration itself.

f. The conditions will protect patients during the period they are in force.

g. It is possible to formulate appropriate and practical conditions to impose on registration and make provision as to how conditions will be monitored."

111. The Committee was of the view that the above factors, apart from (c) applied in this case. Furthermore, conditions would allow the Registrant time to demonstrate that his standards had improved and complete his remediation.

112. The Committee noted that the Registrant had indicated, through his legal representative, that he would be willing to comply with an order of conditions. In addition, the Committee was of the view that there were several identifiable areas in the Registrant's clinical practice in need of supervision, assessment or retraining.

113. The Committee considered whether it would be possible to formulate appropriate and practical conditions in this case. The Committee noted that at paragraph 21.19 of the Guidance, it states that,

> *"The objectives of any conditions placed on the registrant must be relevant to the conduct in question and any risk it presents."*

114. The Committee had regard to the template for conditions of practice in the conditions bank (included at the end of the Guidance) and identified conditions that would be relevant and appropriate. The Committee was of the view that it would be possible to formulate appropriate and practical conditions in this case, relevant to the misconduct.

115. The Committee determined that conditions would be the appropriate and proportionate sanction in this case, and that workable and measurable conditions could be formulated to protect the public and adequately meet the public interest. The Committee did have concerns at the impairment stage regarding the Registrant's level of insight and remediation. However, conditions would give the Registrant the opportunity to develop his insight and to remediate further. In the circumstances, it was not necessary for the Committee to go on to consider a more severe sanction, such as suspension.

116. The Conditions which the Committee determined to impose are set out below at the end of the determination. In summary, the Committee considered that it was necessary and appropriate for there to be workplace supervision, including the regular observation of the Registrant's sight tests, the random review of their patient records, and the requirement to provide a timely and up to date PDP. In addition, the Committee considered that it was necessary and appropriate to restrict the Registrant's supervision of pre-registration Optometrists during the period of conditional registration, given the clinical concerns that had been identified in this case, which had not yet been fully remedied.

117. In relation to the length of order, the Committee determined that, having balanced the mitigating and aggravating factors against the public interest, it would be necessary and proportionate for the Registrant to practice under conditions for a period of 2 years. The Committee considered that the Registrant

needed this length of time to develop his insight further, complete his remediation and to evidence relevant improvements in his clinical practice.

118. The Committee considered whether to direct that a review hearing should take place before the order expired. The Committee noted that at paragraph 21.32 of the Guidance, it states that a review should normally be directed before the end of the order, because the Committee will need to be reassured that the Registrant is fit to resume unrestricted practice.

119. The Committee bore in mind that it had found that there remained a real risk of repetition of the conduct, as the Registrant had limited insight and had not fully remediated. The Committee considered that in the circumstances, and given the length of the conditions of practice order, a review hearing was necessary and proportionate and decided to direct a review hearing sooner than the end of the order, so that the Registrant's progress could be closely monitored. If the Registrant showed sufficient improvement at any earlier stage, the length of the order could be reconsidered by the reviewing Committee.

120. The Committee therefore imposed an order for conditions for a period of 2 years, with a review hearing to take place after nine months. It is noted that further reviews may be directed in due course.

121. The Review Committee will need to be satisfied that the Registrant:

(i) has complied with the conditions of registration,
(ii) has fully appreciated the gravity of the misconduct,
(iii) has not repeated it and has maintained his skills and knowledge and
(iv) that the Registrant's patients will not be placed at risk by the resumption of unrestricted practice,
(v) that the Registrant is spending an appropriate length of time with his patients, to ensure a thorough and considered consultation, broadly in line with the time estimates in Professor Harper's report.

122. In addition, the Committee considers that it would assist the Review Committee if the Registrant was able to provide the following:

(i) Evidence of further reflection in an updated reflective statement, including reflections on the motivations behind his misconduct occurring and the impact upon patients of receiving inadequate sight tests;
(ii) A timely and up to date PDP, with any evidence of further relevant CPD or remediation undertaken;
(iii) Any evidence of how the Registrant has addressed the concerns outlined in Professor Harper's report, including how any learning has been implemented by the Registrant into his clinical practice, with tangible examples.

Immediate Order

123. Although the Committee had heard preliminary submissions from the parties on this issue, following the handing down of the sanction determination, it invited further representations from the parties on whether an immediate order of conditions should be imposed.

124. Mr Renteurs, on behalf of the Council, invited the Committee to exercise its discretion to impose an immediate order of conditions under Section 13I of the Opticians Act 1989 and referred back to the submissions that he made previously.

125. Mr Renteurs addressed the Committee in relation to the case of *Aga v General Dental Council (GDC)* [2023] EWHC 3208 (Admin), which was a recent decision on the interpretation of the operation of immediate orders. Mr Renteurs stated that this case was controversial as it had reversed the longstanding position taken previously by the GDC, and many other regulators, and was currently under appeal by the GDC. Further, whilst the Council had not given any guidance on this matter, the GDC had advised that its existing Guidance on immediate orders should be followed pending the outcome of the appeal in *Aga*.

126. Mr Renteurs submitted that *Aga* could be distinguished from the present case, as it may make a difference that *Aga* was concerned with a nine month suspension order and the risk of it exceeding the statutory maximum of twelve months due to the imposition of an immediate order. Mr Renteurs referred to the decision of Mr Justice Ritchie, at paragraph 100, where he stated that,

> *"It is wrong and unjust to make a direction for suspension and an immediate suspension order which together have the effect of increasing the length of the suspension, beyond the statutory maximum, just because the dentist appeals."*

127. Mr Renteurs submitted that this concern was not going to arise here, as a two year period of conditions had been imposed and any appeal would be likely to be heard within a year. Therefore, this was not a case where there was a danger of the interim order taking the Registrant past the statutory maximum of three years.

128. Ms Vanstone, on behalf of the Registrant, submitted that an immediate order was not necessary given that the Registrant had been in unrestricted practice for the past five years and no interim order had been imposed. In relation to the public interest ground that the Council had referred to, Ms Vanstone submitted that the public interest would be upheld by the substantive order.

129. In relation to the case of *Aga*, Ms Vanstone submitted that she accepted the point that this was a controversial decision but mainly that was because there was no agreed position on it by the parties coming before regulatory tribunals. The fact remains that it is currently the most recent authority on immediate orders and

as the decision of a higher court, it was binding. Ms Vanstone submitted that the fact that there is no Council guidance upon the position carries little weight.

130. Ms Vanstone accepted that the case of *Aga* related to a suspension order, however that does not make it irrelevant. She submitted that it was still relevant as to the only correct and lawful way to make an immediate order, which following the decision of *Aga*, must be worded the correct way. Ms Vanstone submitted that the principle remains the same that there should only be one order and an immediate order should not have the purpose of extending the period of the substantive order.

131. When asked by the Chair of the Committee as to whether she had any submissions on public protection, Ms Vanstone submitted that the Registrant had made full admissions, some of which since March 2024, and had still been in unrestricted practice since then. Whilst a risk of repetition had been identified by the Committee, Ms Vanstone submitted that this risk was not so high as to warrant an immediate order being necessary.

132. The Committee accepted the advice of the Legal Adviser, which was that to make an immediate order, the Committee 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. The Legal Adviser referred the Committee to the relevant section of the Guidance. In relation to the case of *Aga*, the Legal Adviser advised that it was currently the only case on this point, which changed the settled position and was currently under appeal, therefore whilst it was a higher authority which was binding, it had to be treated with some caution.

133. The Committee had regard to the submissions from both parties, the Legal Advice, the Guidance and the statutory test for making an immediate order. The Committee was also provided a copy of the decision from *Aga*.

134. When considering whether an immediate order was necessary, the Committee was mindful that the Registrant had not been subject to an interim order and it was five years since the misconduct occurred. However, the Committee concluded that an immediate order was necessary for the protection of the public, given the nature of the misconduct, which raised a range of clinical concerns, that had not been remedied in the five years since and its findings on impairment that there was a real risk of repetition.

135. The Committee was concerned that if no immediate order of conditions was made, the Registrant could potentially return to practise unrestricted and no order would be in place during any appeal period. The Committee therefore concluded that an immediate order was necessary to protect members of the public in this case.

136. In the circumstances, the Committee decided that it was also otherwise in the public interest that an immediate order be imposed, given that the Registrant

is not currently fit to practise unrestricted and the real risk of repetition. The Committee considered that an impartial and well informed member of the public would be concerned if no immediate order was made.

137. The Committee had regard to the case of *Aga* and was of the view that it was correct to draw a distinction between that case and the present, as that related to an order of suspension, not conditions, and to the risk of exceeding the statutory maximum period. The Committee was satisfied that this risk was not present here, as a two year period of conditions had been imposed and it was unlikely that any appeal would exceed the statutory maximum for conditions of three years.

138. Furthermore, the Committee was mindful that it had directed a review hearing to take place after nine months, and this hearing would provide an opportunity for the Registrant to evidence that he had addressed the concerns identified by the Committee. This was very much in the Registrant's own hands. At that point the order including the further duration of the order could be reconsidered, if the Reviewing Committee thought it appropriate. The Committee was therefore satisfied that, having considered the case of *Aga,* that an immediate order was the appropriate order to make, without needing to set off the period of the immediate order against the period of the substantive order.

139. Accordingly, the Committee directed that the order of conditions should have immediate effect.

Revocation of interim order

140. There is no interim order to revoke.

Chair of the Committee: Mr Graham White

Signature …… …. **Date: 12 August 2024**

Registrant: Mr Ateeq Ashraf

Signature ……sent via email…… **Date: 12 August 2024**

List of conditions

A1.1 Informing others	You must inform the following parties that your registration is subject to conditions. You should do this within two weeks of the date this order takes effect. a. Any organisation or person employing or contracting with you to provide paid or unpaid optical services, whether or not in the UK (to include any locum agency). b. Any prospective employer or contractor where you have applied to provide optical services, whether or not in the UK. c. Chairman of the Local Optometric Committee for the area where you provide optometric services. d. The NHS body in whose ophthalmic performer or contractor list you are included or are seeking inclusion.
A1.2 Employment and work	You must inform the GOC if: a. You accept any paid or unpaid employment or contract, whether or not in the UK, to provide optical services. b. You apply for any paid or unpaid employment or contract to provide optical services outside the UK. c. You cease working. This information must include the contact details of your prospective employer/ contractor and (if the role includes providing NHS ophthalmic services) the relevant NHS body.

A1.3 Supervision of Conditions	You must: a. Identify a workplace supervisor who would be prepared to monitor your compliance with numbers A 1 . 3 , A4.1, A4.4, and A4.5 of these conditions. b. Ask the GOC to approve your workplace supervisor within two weeks of the date this order takes effect. If you are not employed, you must ask t h e G O C to approve your workplace supervisor before you start work. c. Identify another supervisor if the GOC does not agree to your being monitored by the proposed supervisor. d. Place yourself under the supervision of the supervisor and remain under his/her supervision for the duration of these conditions. e. Arrange for your supervisor to directly observe you performing sight tests on at least five randomly selected patients, each week, and to complete a log for each one. Their logs must include information relating to (i) The duration of each sight test observed; (ii) Each patient's age; (iii) Your supervisor's comments regarding the adequacy of your sight test and patient record cards, paying particular attention to the specific areas highlighted in condition A4.5 a) i) – vii) (see below). f. Arrange for your supervisor to keep a log of all patients seen by you with the exact clinical testing times and their age. g. At least once a month meet your supervisor face to face to review your compliance with these conditions, with a particular focus upon f) and to discuss your progress under your personal development plan. h. At least every three months or upon request of the GOC, request a written report from your supervisor to be provided to the GOC, detailing how you have complied with the conditions he/she is monitoring including the logs referred to at e) and f) above. i. Inform the GOC of any proposed change to your supervisor and again place yourself under the supervision of someone who has been agreed by the GOC.

A1.4 Other proceedings	You must inform the GOC within 14 days if you become aware of any criminal investigation or formal disciplinary investigation against you.
A1.5 Registration requirements	You must continue to comply with all legal and professional requirements of registration with the GOC. A review hearing will be arranged at the earliest opportunity if you fail to:- a. Fulfil all CPD requirements; or b. Renew your registration annually.

A4.1 Restriction on practice	You must: a. Not undertake any supervision of pre-registration Optometrists for the duration of these conditions.

A4.4 Assessment of records	You must: a. In consultation with the Chairman of your Local Optometric Committee or your workplace supervisor, identify an independent assessor (**not** your workplace supervisor) who is willing to review a randomised selection of your most recent patient records, selected by them. b. Provide the assessor with a copy of Professor Harper's reports and arrange for the assessor to review 20 of your most recent patient records, selected at random by the assessor, within one month of these conditions taking effect, and on a monthly basis thereafter. c. Every three months and at least two weeks before any review hearing, provide the GOC and your workplace supervisor, with a written report from the independent assessor, setting out his/her views on the adequacy and completeness of the records reviewed, including his/her views on the deficiencies identified in the reports of Professor Harper as set out in A4.5 a) (i)- (vii)

A4.5 Personal development plan	a. You must work with your workplace supervisor to formulate a personal development plan, which should be specifically designed to address the deficiencies identified in the reports of Professor Harper, namely in the following area(s) of your clinical practice: i) Visual field testing; ii) Measurement of intraocular pressures; iii) Assessment of basic binocular vision using appropriate cover tests; iv) Pupil assessments; v) Tailoring your records to individual patients; vi) The duration of your sight tests; vii) Record-keeping. b. Submit a copy of your personal development plan to the GOC for approval within one month of these conditions taking effect. Your personal development plan should be kept under review and updated as required following discussions with your workplace supervisor. Any updated personal development plan must be submitted promptly to the GOC.

NOTICE TO REGISTRANT:

- The GOC will enter these conditions against your name in the register save for any conditions that disclose information about your health.
- In accordance with Section 13C(3) of the Opticians Act 1989, the GOC may disclose to any person any information relating to your fitness to practise in the public interest.
- In accordance with Section 13B(1) of the Opticians Act 1989, the GOC may require any person, including your learning/workplace supervisor or professional colleague, to supply any information or document relevant to its statutory functions.

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.