BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(23)35

AND

MOHAMMED WAHEED ZADA (01-28961)

DETERMINATION OF A SUBSTANTIVE HEARING
4 – 5 December 2023,
13 February 2024,
7 and 10 May 2024

Committee Members:	Jayne Wheat (Chair) Ubaidul Hoque (Lay) Amit Jinabhai (Optometrist) Amanda Webster (Lay)* Amritpreet Basra (Optometrist)* *did not sit at the sanction stage (7 and 10 May 2024)
Clinical advisers:	Dr Muthukrishnan (4-5 December 2023) Dr Desmond Dunleavy (13 February 2024, 7 and 10 May 2024)
Legal advisers:	Ini Udom (4-5 December 2023 and 13 February 2024) Aaminah Khan (7 and 10 May 2024)
GOC Presenting Officer:	Ms Tope Adeyemi (4-5 December 2023) Dr Francis Graydon (13 February 2024, 7 and 10 May 2024)
Registrant present/represented:	Yes, and not represented
Registrant's representative	N/A
Hearings Officer:	Nazia Khanom Humera Asif Latanya Gordon
Facts found proved:	Allegation 1,2 and 3
Misconduct:	Found
Impairment:	Impaired

Sanction:	Suspension for 9 months (Without Review)
Immediate order:	No

Preliminary matters

1. The Registrant made an application at the outset of the hearing that certain matters be dealt with in private, namely any discussion concerning his [redacted] and the period in which [redacted]. Given the nature of the application, the Committee determined that the application itself should be heard in private. He explained that he was concerned about the impact of such matters becoming public and the impact that would have on him and [redacted], not only socially, but also in terms of their safety. In relation to the application Ms Adeyemi, on behalf of the General Optical Council ('the Council') submitted that the Council's position was neutral.
2. The Committee was advised by the Legal Adviser that pursuant to Rule 25 of the General Optical Council (Fitness to Practise) Rules 2013 ('the Rules') proceedings should be heard in public. This is the default position. The Rules, however, did allow for exceptions to this approach. The relevant exception would be Rule 25 (2)(c) – 'the interests of the Registrant'. The Committee was reminded that transparency is a fundamental principle of good regulation and that a balancing exercise must be performed. The Committee accepted the advice of the Legal Adviser.
3. The Committee was satisfied that when dealing with the matters raised by The Registrant the hearing should proceed in private. It determined that the reservations and concerns raised by The Registrant were reasonable. It was particularly mindful that the fairness of the proceedings had to be protected – The Registrant had to be enabled in giving his evidence and be able to respond to questions freely, openly and without fear of repercussions. His interests would most likely be adversely affected if matters were discussed publicly. A fair and proportionate measure to achieve this would be for aspects of the hearing to be conducted in private.
4. The Committee further noted that all matters relating to The Registrant's [redacted] would also be addressed in private pursuant to Rule 25(3). All other parts of the hearing would be conducted in public.

ALLEGATION

The Council alleges that you, Mohammed Waheed Zada (01-28961), a registered optometrist:

1. In or around May 2020 to May 2021, you carried out your duties as an Optometrist without having adequate professional indemnity insurance; and/or

2.In January 2021 you completed the GOC retention form online and inserted your Association of Optometrists (AOP) membership number from a previous year, to show you had adequate professional indemnity insurance, when you did not have the cover for that period; and/or

3. Your actions at (1) and (2) above were dishonest in that:

a. You knew you were not insured to carry out your duties as an Optometrist.
b. You knew you, did not have adequate professional indemnity insurance when you completed your GOC retention form.

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

5. The Registrant admitted particulars 1, 2 and 3 of the Allegation.

Background to the allegations

6. The Registrant first registered with the General Optical Council ("GOC" / "Council") as a student optometrist on 28 September 2011 and became a fully qualified Optometrist registered with the Council on 13 October 2015.

7. On 29 September 2021, a self-referral was submitted to the Council by solicitors instructed on behalf of the Registrant to advise that he had been practising as an Optometrist between May 2020 and May 2021 whilst he was uninsured. It was also disclosed in the same letter that the Registrant had informed the Council that he was insured when he was not. Within the self-referral it was also noted that the Registrant had subsequently been [redacted].

8. In light of the information provided, the Council commenced an investigation into the Registrant's conduct. The stores at which the Registrant had worked at as an Optometrist during the relevant period were asked to provide information on his indemnity insurance status. They each confirmed that Registrant had been employed as a locum and that the expectation was that he had his own indemnity insurance.

9. The evidence before the Committee confirmed that the Registrant had used an Association of Optometrists ('AOP') membership number from a previous year to indicate to the Council that he had adequate indemnity cover when applying to maintain his GOC registration.

10. The Committee was provided with information from the AOP which confirms that the Registrant was not a member from 1 May 2020 to 30 April 2021. The Registrant has stated that he worked as an Optometrist for 87 days during this period.

Findings in relation to the facts

11. The Committee, upon the Registrant's admissions to the Allegation particularised at 1, 2 and 3 found those facts proved. This was announced by the Chair in accordance with Rule 46(6). On behalf of the Council, Ms Adeyemi then opened their case.

Evidence and submissions in relation to Misconduct and Impairment

12. The Committee took account of all the documentary evidence before it provided by the Council and the Registrant. The Committee had particular regard for the Registrant's comprehensive statement of reflection entitled 'Reflections on working without insurance'. The Committee heard evidence from the Registrant in relation to misconduct and impairment together and then heard submissions from Ms Adeyemi, on behalf of the Council, and the Registrant in relation to misconduct and impairment.

13. Ms Adeyemi, in summary, submitted that the facts found proved amounted to misconduct. She referred to the skeleton argument provided by the Council. It was stated that the Committee should have regard to the GOC's Standards of Practice for Optometrists and Dispensing Opticians, effective from April 2016 and that it may wish to consider that the Registrant has departed from the following standards by virtue of his conduct:

    - Standard 12.2: Have adequate professional indemnity insurance and only work in practices that have adequate public liability insurance.
    - Standard 12.2.1: If insurance is provided by your employer, you must confirm that adequate insurance is in place.
    - Standard 12.2.2: If you work in multiple practices, you must ensure that there is adequate insurance to cover each working environment.
    - Standard 12.2.3: Your professional indemnity insurance must provide continuous cover for the period you are in practice.
    - Standard 16: Be honest and trustworthy.
    - Standard 17: Do not damage the reputation of your profession through your conduct.

14. The Registrant, in his oral evidence, agreed that the facts found proved amounted to misconduct. He stated that it must be regarded as misconduct of the highest order.

15. He explained that at the time of the conduct in question he was in the deepest, darkest place that he had experienced in his life. He told the Committee that he had [redacted].

16. He further explained that he had since rebuilt his personality and realised the magnitude of what he had done. He had spent years now engaged in self-

reflection within the private confines of his home but also in [redacted]. Through this he was able to see through the façade that had been in place during the period of his misconduct. He accepted that he had attended on patients who had made themselves vulnerable to him and were under an illusion that he was fully and correctly insured. He told the Committee that the Council was unaware, as was the AOP. He accepted that he had intentionally fooled his contractors. He accepted that he had lied to his Regulator and broken contracts he had signed with his own hands. In relation to his treatment of the contractors he stated he had disrespected and dishonoured them.

17. He stated that he wanted to publicly apologise to patients, whom he said he loved. He acknowledged that each person deserved the best treatment. He also apologised to the directors who contracted with him, the AOP and the Council. He acknowledged he had broken the trust that had been placed in him and also the role and function of the Council and AOP. He accepted that through his actions significant time and resources had been spent on fitness to practise procedures.

18. The Committee heard submissions from Ms Adeyemi on behalf of the Council and evidence and submissions from the Registrant in relation to impairment.

19. In summary, Ms Adeyemi, on behalf of the Council, submitted that that the need to uphold professional standards and maintain public confidence in the profession is paramount and must outweigh the interests of the Registrant. In light of the facts found proved, the Council submitted that a finding of no impairment would wholly undermine public confidence in the profession and the Regulator.

20. In addressing the question of impairment, the Registrant submitted that his conduct did amount to misconduct and that he was impaired during 2020 and 2021. He also accepted that he was currently impaired. He suggested that this would be an uncontroversial conclusion. He had acted against the law, the Standards and breached contracts. He told the Committee that he had had two fitness to practise proceedings brought against him in relation to his behaviour within a distinct period of time, which he described as the hardest period of his life. He confirmed that at the time of the relevant events he had not realised that he was [redacted]. He said that this was dangerous to mix with patient care.

21. [Redacted]

22. The Committee heard that he had worked hard and exposed himself to uncover the realities of how he was in 2020 – 2021. He was striving to rehabilitate his character. This had not been easy but had resulted in a complete change in his persona. He had changed the company that he keeps. He had engaged with [redacted]. The rediscovery of his [redacted] enabled him to reframe his world view, providing space for reflection and also caution. He stated that whilst he was not perfect, he was a far cry away from who he had been.

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23. He explained that he now has a number of methods in place to help him such as breathing exercises, prayer, meditation and reflection. He now recognises when he is overstretched. Previously his ego would have led to him dismissing such a realisation and pressing on.

24. He asked the Committee to bear in mind that he had disclosed his dishonesty of his own volition, at a time when he had lost his dream career as a doctor and the loss of all the resources and effort that he put into that pursuit. He was not under investigation in relation to his indemnity insurance non-compliance and he had already re-instated his insurance. However, he felt compelled to disclose his conduct in the full realisation of the potential consequences to his career as an Optometrist. He felt that this was an occasion when he had to advocate against himself.

25. He provided the Committee with a video of his AOP account showing that he was issued with an insurance certificate indicating that he was insured from 01
January 2021 to 31 December 2021. In fact, he had only submitted the renewal in May and so would not have been covered for the January to May 2021 period. The certificate had been issued by the AOP, with the period showing as a default of 12 months. He explained that he could have used this document in his defence but had decided not to take that course, but rather fully and frankly accepted the full extent of his dishonesty.

26. In conclusion, the Registrant stated that he believed that his fitness to practise was currently impaired solely on the ground of the public interest. He said that he had committed serious and heinous actions over such a long period, 87 times. He told the Committee that the original reasons for impairment, namely his dishonesty, lack of integrity and character flaws had been remediated to an extent that he was no longer impaired in those personal respects.

27. [Redacted]

28. [Redacted]

29. [Redacted]

30. In the circumstances, the content of the reports was useful to this Committee only in that they provided further context as to the events and [redacted] around the time of this Allegation.

31. The Committee accepted the advice of the Legal Adviser that it should consider whether the alleged ground of impairment under Section 13D of the Act, specifically misconduct, was established and that it could consider all written material provided by the parties.

32. In relation to misconduct, the Legal Adviser referred to the case of *Roylance v General Medical Council (No2) [2000] 1 AC 311*, regarding the two principal kinds of misconduct, either conduct linked to professional practice or conduct that otherwise brings the profession into disrepute. The Committee was reminded that misconduct was a matter for its own independent judgement. Further, that the Committee needed to consider whether the conduct was sufficiently serious to amount to professional misconduct.

33. This threshold of serious misconduct has been described in the case of *Meadow v General Medical Council [2006] EWCA Civ 1390* as being conduct which would be regarded as deplorable by fellow practitioners.

34. The seriousness with which dishonesty is regarded was highlighted to the Committee with reference to the cases of *Nandi v General Medical Council [2004] EWHC 2317 (Admin)* and *Lawrence v General Medical Council [2015] EWHC 586.*

35. In relation to impairment the advice given by the Committee's Legal Adviser highlighted that the Committee should have regard to all of the material before it when determining impairment. It was reminded that consideration of the level of insight, remorse, reflections and attempts at remediation shown by the Registrant is central to a proper determination of impairment.

36. The Legal Adviser referred the Committee to the questions posed in considering impairment as set out by Dame Janet Smith in the fifth report of the Shipman Inquiry, and cited with approval in the case of *CHRE v NMC & Paula Grant [2011] EWHC 927 (Admin) ('Grant')*, para 76, by Mrs Justice Cox, which requires the Committee to ask whether its 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 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 profession and/or
    d. has in the past acted dishonestly and/or is liable to act dishonestly in the future".

37. It was stressed that the Committee must look forward not back when determining impairment and it was referred to the case of *Cohen v General Medical Council [2008] EWHC 581 (Admin)*. If its decision was that fitness to practise is not impaired, then the Committee must make clear in its determination what remedial steps have been taken into account.

38. As to the public interest, the Legal Adviser referred again to the case of *Grant* in which the High Court said that, in deciding whether fitness to practise is impaired, the Committee should ask themselves:

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

39. The Committee was also referred to the case of *Yeong v General Medical Council [2009] EWHC 1923 (Admin)*. The Committee was reminded that it should consider the Hearing and Indicative Sanctions Guidance.

40. The parties agreed with the Legal Adviser's advice, which the Committee accepted.

Findings on Misconduct

41. The Committee noted the Registrant's characterisation of his conduct as "*heinous*" and "*at the highest end of the spectrum*". Nevertheless, it proceeded on the basis that the decision was one for the judgement of the Committee and it alone.

42. The Committee bore in mind the cases of *Nandi, Lawrence* and *Remedy* and noted that in the ordinary course of matters dishonest conduct was likely to lead to a finding of misconduct.

43. The Committee reminded itself that the Registrant was under a statutory obligation to have professional indemnity insurance in place pursuant to section
10A the Opticians Act 1989.

44. The Registrant's dishonesty did not consist of a single act, perpetrated against single individual / entity. There were a number of elements to it. He lied to his Regulator, he breached his contracts with Directors who had placed trust in him, he breached the trust of patients who turned to him for optometric care.

45. The Registrant had accepted that he knew that indemnity insurance was required and that he was contractually bound to have it in place. By his own admission he practised on 87 days with a full clinic whilst uninsured. Patients were knowingly put in a position where they were being treated by an uninsured Optometrist. The dishonesty was deliberate and sustained over a period of approximately a year.

46. The Committee was mindful that the Registrant had notified the Council of his dishonesty on 29 September 2021. This was of his own accord. This was, however, some three months after he had properly obtained insurance. It was not a case of immediate notification following the dishonest act. It further noted that the Registrant was under a professional duty to co-operate with his Regulator and keep it notified of any irregularities. In the circumstances the notification did little to reduce the seriousness of the dishonest conduct.

47. The Committee determined that the Registrant's behaviour would be regarded as deplorable by fellow members of the profession. It further concluded that members of the public would be shocked and alarmed to learn of his conduct. The conduct fell far short of how the public would expect an Optometrist to behave and was sufficient to bring the Optometric profession into disrepute.

48. The Committee considered that the Registrant's conduct was in breach of the multiple Standards as identified by Ms Adeyemi on behalf of the Council, namely
12.2, 12.2.2, 12.2.3 (with the exception of 12.2.1 which was not engaged in the Committee's view) and 16 and 17. The Committee identified Standard 6.4, set out below, which the Registrant had referred to, as also being breached:

> *Understand and comply with the requirements of registration with the General Optical Council and the legal obligations of undertaking any*

functions restricted by law, i.e. sight testing and the sale and supply of optical devices.

49. The Committee determined the actions of the Registrant amounted to serious misconduct.

Findings on Impairment

50. The Committee carefully considered the evidence, both oral and documentary, the submissions made and the advice received.

51. The Committee was assisted by the guidance provided by the case of *Grant*. It noted that patients had been treated by an uninsured Optometrist. If any issues had arisen following the treatment their ability to access recourse for compensation would have been jeopardised. During his evidence, Registrant himself stressed that this had occurred on multiple occasions. Further, the Committee considered that any undermining of trust in the profession could in turn impact on patient safety. Patients must be able to wholeheartedly trust in their providers of optometric care. If that is undermined or lost patients could become avoidant in seeking treatment and advice to the detriment of their ocular health. It, therefore, considered that the Registrant had in the past placed patients at an unwarranted risk of harm.

52. It considered that his conduct had in the past brought the profession into disrepute. As stated above members of the public would be shocked to hear of his conduct and fellow practitioners would be dismayed.

53. The Registrant had in the past breached one of the fundamental tenets of the profession, namely, to act with honesty and integrity. He had also breached a statutory requirement to have insurance in place when in clinical practice.

54. It was clear on the face of the admitted and proved Allegation that he had in the past acted dishonestly. In this regard the Committee was mindful of the previous Fitness to Practise proceedings against the Registrant which also involved an allegation of dishonesty. In that case it was found proved that on 9 March 2021 he had falsified his GP's signature on an Adult Health form and that his actions were dishonest, as he knew that the signature provided was false. This occurred within the time frame that this Committee is concerned with.

<u>Future risk</u>

55. The Committee carefully considered the likelihood of the Registrant carrying out future acts of misconduct, specifically whether he:

    a. is liable in the future to act so as to put a patient or patients at unwarranted risk of harm;

    b. is liable in the future to bring the profession into disrepute;

    c. is liable in the future to breach one of the fundamental tenets of the profession;

    d. is liable to act dishonestly in the future.

56. The Committee considered whether the Registrant's conduct was remediable and found that, whilst dishonesty is notoriously difficult to remediate because it is attitudinal in nature, it can be done. The Committee had before it evidence of significant efforts having been made by the Registrant.

57. The Committee determined that the Registrant had successfully provided evidence of remediation. The Committee found that a number of wide-ranging steps had been taken by the Registrant to effect remediation, including:

    a. Voluntary disclosure of the dishonesty to the GOC.

    b. Relevant and targeted CPD training on dishonesty, probity, accountability and ethics.

    c. Attendance at counselling sessions and other steps taken to address his [redacted].

    d. His use of a [redacted], a safeguarding, protective measure.

    e. The creation of a support network around him.

    f. His frank disclosure of his previous conduct to his current workplace colleagues. They are aware that he has [redacted] and are therefore able to provide support where necessary.

    g. The heartfelt apology offered in his oral evidence to all affected by his conduct.

58. The Registrant spoke cogently about his recognition that personality traits and ego were at the heart of the cause for his conduct. This must be considered against the background of significant difficulties in his personal life that impacted upon the Registrant during the period with which this Committee is concerned. The Committee considered that the Registrant's circumstances, in terms of his [redacted] and personal life, his mindset and [redacted], are very different now to what they were at the time of the Allegation.

59. The Registrant expressed clear and credible remorse. It was noted that there was evidence before it of proper indemnity insurance being in place ever since the conduct in question and that he gave evidence that demonstrated his full understanding of the importance of compliance.

60. The Committee considered the level of insight demonstrated by the Registrant. It bore in mind the oral and written evidence given to it by the Registrant. The Committee was satisfied that he has an understanding and awareness of his motivations and triggers. He had taken full responsibility for his actions and not sought to apportion blame. The Committee was presented with evidence of meaningful reflection. It was clear that he understood the impact of his actions on the professional community, his patients and the wider public. The Committee concluded that he now showed good insight into his misconduct.

61. In light of its findings in relation to remediation and insight, the Committee was satisfied that the risk of repetition in all of the areas set out above is highly unlikely. The Registrant has put in place thorough strategies to avoid the risk of repetition of his misconduct. He has taken significant steps to analyse and understand the cause of his previous behaviours and built a support network around himself.

Public interest

62. The Committee noted that the allegations before it represented deliberate, repeated and sustained acts of dishonesty. The misconduct was serious and described as heinous by the Registrant. The Committee agreed. His acts impacted upon numerous categories of people and organisations.

63. In these circumstances, the Committee was satisfied that the Registrant's dishonest conduct was a serious departure from proper professional standards which could damage public confidence in the Optometric profession.

64. Ultimately, the Committee was satisfied that there was a need to uphold proper professional standards and conduct, and that public confidence in the Registrant, the Regulator and the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case.

65. With all of these considerations in mind the Committee found that the fitness of the Registrant to practise as an optometrist is currently impaired on the ground of the public interest alone.

Decision to adjourn

66. This matter was listed for a resumed hearing today having previously been heard on 4 – 5 December 2023, when the Committee determined that the Registrant's fitness to practice was impaired.

67. At the outset of this hearing, before moving to consider sanction, the Committee explored whether there was any further evidence to be presented at the sanction stage. This was raised because an anomaly in the [redacted] evidence had been noted and highlighted previously, in the determination on impairment, and subsequently by email to the Hearing's Manager.

68. The Case Examiners had commissioned an expert report from Professor Rana in these proceedings. Within that report Professor Rana addresses the misconduct alleged, now found proved, and purports to address the questions specifically raised by the Case Examiners. This Committee noted in its findings on impairment the following:

> *29.* [Redacted]
>
> *30. In the circumstances, the content of the reports was useful to this Committee only in that they provided further context as to the events and* [redacted] *around the time of this Allegation.*

69. The confusion inherent in Professor Rana's conclusions was in relating any nexus between the [redacted] and misconduct to the facts of an earlier set of fitness to practise proceedings, and not to the facts of this case (namely practising without indemnity insurance).

70. The Committee raised with the parties its concern over the lack of clarification in relation to Professor Rana's report.

71. On behalf of the Council Dr. Graydon confirmed that the Registrant had contacted the Council on 26 July 2023 to highlight the mistake in the report and request correction. The Council had responded to him no other action was taken. Dr Graydon submitted that he could not comment on the findings of Professor Rana – his report was silent on the nexus between the [redacted] and his misconduct. The issue would be the weight, if any, when considering sanction, that can be attached to the [redacted].

72. The Registrant expressed his confidence that the Committee would be able to read between the lines and understand what Professor Rana intended to convey in his report. He stated that he knew that the oral evidence that he had given at the impairment stage would be fully considered, but that he would be upset if he received a more severe sanction because there was information missing from the report of Professor Rana.

73. The Committee retired to consider the position. The anomaly has not been addressed and therefore, the Committee, having noted its previous concerns around the available evidence, was placed in an invidious position.

74. The Committee confirmed that it agreed with the position of Dr Graydon, in that it was not open to the Committee to go behind the report of Professor Rana. It was troubled by the position and sought legal advice from the Legal Adviser. The Committee returned to the hearing to further clarify its concerns and for the Legal Adviser to put her advice on record for the parties.

75. The Legal Adviser reminded the Committee of the purpose of sanction and stressed that it extended to the confidence of the public in the fairness and propriety of the regulatory process. She also drew the Committee's attention to the indicative Sanctions Guidance. She highlighted the seriousness of a finding of dishonesty and also the fact that the Guidance specifically addressed [redacted].

76. The Legal Adviser directed the Committee to the case of *Sun vs General Medical Council [2023] EWHC 1515* and the approach advocated therein. The Committee would have to carefully consider the nexus between [redacted] and the misconduct found proved. [Redacted] can be a mitigating factor and the Committee would have to consider what weight, if any to place upon it as a mitigating factor in the circumstances of this case. Any relevant [redacted] would therefore have to be carefully considered.

77. The Committee accepted the advice of the Legal Adviser and invited submissions from the parties as to whether the case should be adjourned.

78. On behalf of the Council, Dr Graydon confirmed that the Council's position was neutral. He noted that the time now remaining available today, for the Committee

to hear the matter was greatly reduced and that this was a factor that should be considered.

79. The Registrant confirmed that his position as also neutral. He stated that he believed the concerns of the Committee were perfectly reasonable.

80. The Committee took advice from the Legal Adviser. The Legal Adviser set out that the Committee does have the power to adjourn proceedings pursuant to the Rules 35 – 37. The Committee was advised that it should consider whether an adjournment would be fair in the circumstances and whether it would be effective in achieving the outcome desired.

81. The Committee accepted the advice of the Legal Adviser and retired to deliberate.

82. The Committee determined that the hearing should be adjourned. It had grave misgivings around continuing with the hearing when it was accepted by all parties that the [redacted] before it contained a clear anomaly. The matter in issue was an important one and would need to be considered carefully when determining what weight to place on the mitigation of there being a prevailing [redacted] at the time of the misconduct.

83. The Committee noted that in the circumstances of the case there was a risk of actual or perceived unfairness if it were to proceed without further clarification from Professor Rana. A relevant question had been posed and left unanswered. As matters stand the evidence around the [redacted] and any nexus there might be with the misconduct found proved was not sound or complete.

84. The Committee were informed that it might be possible to make contact with Professor Rana and obtain a verbal update in relation to his report. However, no actual enquiries were made by the GOC to effect this. In any event, the Committee was of the view that this would likely be impracticable. It is unlikely that the Professor would be available at such short notice, coupled with the lengthy period of time that has elapsed since he produced the report. Furthermore, the Registrant is unrepresented and there remains limited time available for the matter to be properly considered and heard today.

85. The Committee was conscious of the impact that a further adjournment would have on the Registrant, who had attended today fully expecting these matters to be concluded. It carefully balanced the impact of an adjournment upon the Registrant with the necessity of ensuring fair, transparent and informed decision making. The Committee decided that it would be in the interests of justice and fairness for the hearing to be adjourned. This was the proportionate way to proceed.

86. The Committee was satisfied that a short adjournment would enable an addendum report to be produced which would address the anomaly identified.

87. The Committee therefore makes the following directions:

    a. The Council is to expedite the resolution of the difficulties that have arisen in this matter, by making contact with Professor Rana at the earliest opportunity.

    b. The Council should provide to the Committee and the parties, no later than 28 days from today, an addendum report from Professor Rana. The report should address the question as to whether there is any nexus between any [redacted] and the misconduct alleged in the current proceedings.

Sanction

88. The Committee reconvened on 7 and 10 May 2024 to consider what would be the appropriate and proportionate sanction, if any, to impose in this case. The Council was represented by Dr Graydon and the Registrant was unrepresented.

89. At the outset of the hearing, the Chair confirmed with the parties that they were content for the hearing to proceed with a panel of three Committee members (the original Committee of five not all being available) and that they agreed the Committee was quorate. Both parties agreed that the Committee was quorate and confirmed that they were content to proceed.

90. The Committee received further documentary evidence at this stage of the proceedings, which consisted of an updated [redacted] report from Professor Rana dated 1 March 2024 and a page from the Registrant's bank statement for the end of November 2023.

91. The Registrant gave further evidence at this stage under affirmation, in relation to sanction. In summary, the Registrant gave evidence that he was incredibly ashamed of his actions and he reiterated his remorse. He accepted that he had been '*brazenly dishonest*' for a period of a year, but had since matured and realised he needed to take account of his actions.

92. The Registrant referred the Committee to his bank statement to show the financial impact that his earlier six month suspension (ordered in separate fitness to practise proceedings) had upon him and his [redacted]. He had obtained employment in [redacted], however this was not well paid and barely covered his bills. The Registrant stated that each month of a suspension had an added and significant effect upon him, as he was the sole breadwinner for his [redacted]. He gave an example of [redacted] and considered that any suspension longer than four months would result in him having to attend food banks.

93. The Registrant acknowledged the seriousness of the misconduct found and accepted that this was '*all his own doing*'. He fully agreed that there needed to be a sanction imposed upon him and this is why he had self-referred to the Council. Further, the Registrant accepted that his own wellbeing fell below the wider public interest and that the Committee's priority in imposing a sanction was to protect the public. However, he reminded the Committee that it had found that repetition was highly unlikely, he had insight and had adequately remediated and impairment was found on public interest grounds alone.

94. The Registrant stated that he "*could not tolerate*" another long suspension and that he felt the nine months suggested by the Council was too harsh. He gave evidence that he had been working for the last few months as a locum Optometrist and felt by doing so he was making a positive difference. He stated that the public would be denied his services if he was suspended.

95. The Registrant gave evidence that whilst this was his second fitness to practise case, both involving dishonesty, they were both from the same time period, when he had lost sense of what was right and wrong. He stated that he was not the same person then as he is now and he had worked really hard to get to where he is now. The Registrant stated that, in his view, the best rehabilitation would be to allow him to return to practice.

96. The Committee proceeded to hear submissions on sanction from Dr Graydon on behalf of the Council and from the Registrant.

97. Dr Graydon reminded the Committee that the decision on sanction was entirely a matter for the Committee's own judgement and the purpose of imposing a sanction was not to punish the Registrant, although it may have that effect. The primary purpose of sanctions was to protect the public and to meet the overarching objective in the Opticians Act 1989. Dr Graydon submitted that when considering the limbs under section 1(2B), the safety of the public may be less relevant in this case than promoting and maintaining public confidence in the profession and proper professional standards and conduct. He acknowledged that this was not a case where there had been clinical failings or deficiencies in the Registrant's practice.

98. Dr Graydon invited the Committee to have regard to the GOC's '*Hearings and Indicative Sanctions Guidance*' (updated November 2021) ('the Guidance'). Dr Graydon reminded the Committee to begin with the least restrictive sanction first and to work through the Guidance until it reached a sanction that met the public interest. Furthermore, he reminded the Committee of the principle of proportionality, which meant not going beyond what was necessary or appropriate in the circumstances.

99. Dr Graydon outlined that the Council's position is than an appropriate and proportionate sanction in this case would be a suspension for a period of nine months, with a review hearing. He highlighted that this was the second set of

fitness to practise proceedings for this Registrant, both involving dishonest conduct. Dr Graydon referred the Committee to the caselaw on dishonesty including *Bolton v Law Society* [1994] 2 All ER 486, *Siddiqui and General Medical Council* [2013) EWHC 1083 (Admin) and *Lusinga v Nursing and Midwifery Council* [2017] EWHC 1458 (Admin). With reference to the case of *Lusinga*, Dr Graydon submitted that there was a scale of dishonesty and the Council's position was that this was at the upper end of the scale.

100. Dr Graydon made specific reference to the paragraphs in the Guidance on dishonesty, at paragraph 22.4 onwards, highlighting that in cases of dishonesty a registrant was at risk of being removed from the Register, although there was no presumption that erasure would be appropriate in all cases. He submitted that the Committee should balance the particular circumstances of this case against the effect any sanction would have on public confidence in the profession and maintaining proper standards and the reputation of the profession. The Council submitted that dishonesty has a serious impact upon public confidence in the profession and in this case it was not an isolated, one-off instance of dishonesty, as the Registrant had practised without insurance for a year, working 87 days, where he would have examined multiple patients. Dr Graydon submitted that the conduct was better described as persistent dishonesty.

101. Dr Graydon submitted that whilst the Registrant has given evidence on the impact that a suspension (and it follows also erasure) would have upon him, the authorities, particularly *Bolton v Law Society*, made clear that this was secondary to the wider public interest and the reputation of the profession.

102. Dr Graydon addressed the addendum report of Professor Rana and submitted that whilst it supported that there was a nexus between the misconduct and the [redacted], it was for the Committee to determine what weight to give that evidence. Dr Graydon submitted that the Committee can be assisted by the case of *Sun v General Medical Council* [2023] EWHC 1515 (Admin), in which the High Court considered that in that case there was no [redacted] present that was capable of excusing or exonerating the misconduct. What was significant was whether the Registrant knew what he was doing and had the relevant state of mind for dishonesty, which Dr Graydon submitted that the Registrant did. Dr Graydon further suggested that at most the [redacted] may be a mitigating factor but it did not alter the character of the misconduct. In this case, the Committee has to consider the length of time that it persisted, and it was multi-faceted in terms of the multiple patients and practices potentially placed at risk of harm.

103. Turning to the sanctions available to the Committee, Dr Graydon submitted that taking no action would be inappropriate, as there were no exceptional circumstances present. Dr Graydon reminded the Committee that a financial penalty was an option available to the Committee and may be given in addition to another sanction but it would not be an appropriate sanction in itself. Dr Graydon submitted that conditions were more appropriate in a case where there

were deficiencies in the Registrant's practice or health issues, which were not the basis for the finding of impairment in this case.

104. Dr Graydon stated that the Council's position was that a suspension for a period of nine months with a review would be an appropriate and proportionate sanction to impose in this case. He highlighted to the Committee the following, which he submitted were aggravating factors:

i) The pre-planning involved;
ii) The prolonged period that the misconduct occurred for;
iii) The risk to patient care and potential harm to a large number of patients;
iv) This is the second case of dishonesty;
v) The misconduct has put the reputation of the profession into disrepute.

105. The Registrant submitted that he did not disagree that the misconduct was serious and prolonged. He also accepted that this was his second fitness to practise case involving dishonesty. However, he highlighted that both cases were from the same time period and there was an overlap in his actions and who he was as a person at that time. The Registrant submitted that the public would not consider that a suspension of more than four months was necessary, particularly when considering that he had already been suspended for six months (on the earlier case), which would be ten months of suspension in total. When looked at together, the Registrant submitted that a ten month period of suspension for both matters was an adequate response.

106. In relation to whether a review hearing was required, the Registrant invited the Committee to consider what a review would actually achieve and what would the next Committee be reviewing at that hearing. He highlighted that the Committee had already found that he has insight, he had largely remediated and that repetition was highly unlikely. The Registrant submitted that a review hearing would also create more uncertainty for him, which psychologically he would find very difficult, as it does not conclude matters.

107. [Redacted].

108. 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.

109. The Legal Adviser reminded the Committee of the guidance arising from the case of *Sun v General Medical Council,* which in summary was that when

assessing the impact of a [redacted] in relation to dishonest misconduct and the appropriate sanction, it should have close regard to other aspects of the dishonesty, such as length of time it persisted. If the practitioner knew what they were doing, then a [redacted] cannot be said to alter the character of the misconduct, excuse or exonerate it. Evidence in relation to [redacted] may still be a relevant mitigating factor and the appropriate weight to be given to it is a matter for the Committee.

The Committee's decision on sanction

110. 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 stage.

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

1) The misconduct was a breach of multiple standards (6.4, 12.2. 12.2.2, 12.2.3, 16 and 17) as well as breaching a fundamental tenet of the profession, namely honesty;

2) There is a fitness to practise history, as there was another incidence of dishonesty, albeit overlapping with the time period for this misconduct;

3) The dishonesty was deliberate, in that the Registrant knowingly deceived both the Council and the various practices that he had worked at;

4) The misconduct was sustained over a period of time, namely for a year in which the Registrant worked 87 locum days, during which hundreds of patients, at different branches, would have been examined without adequate insurance cover in place;

5) The Registrant knowingly put patients at risk of harm as a result of practising without adequate insurance cover.

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

1) At the relevant time the Registrant was going through significant difficulties in his personal and [redacted] life;
2) The Registrant made full admissions to the allegation at an early stage;
3) The Registrant self-referred his misconduct to the Council in 2021;
4) The Registrant has demonstrated genuine remorse, regret and has sincerely apologised;

5) The Registrant has demonstrated substantial insight into his misconduct and [redacted], he has successfully remediated, with the Committee finding that repetition is highly unlikely;

6) [Redacted]

113. The Committee considered, with regard to the aggravating and mitigating factors, where the misconduct in this case sat on the scale of dishonest conduct (as per the case of *Lusinga v Nursing and Midwifery Council* [2017] EWHC 1458 (Admin)). The Committee was of the view that when evaluating the nature and character of the dishonesty, it was not at the very top, but was towards the higher end of the scale of seriousness.

114. The Committee considered the impact of the Registrant's [redacted] upon the misconduct. [Redacted].

115. The Committee also had regard to the Registrant's own evidence, in which he had stated that he was not seeking to use [redacted] as a '*scapegoat*' and that he had acted in a manner that was '*brazenly dishonest for a year*'. The Committee also noted that the Registrant had made admissions to being dishonest and that the dishonesty was maintained for a year, involving 87 days of practice without insurance and several contractors. The Committee considered that the evidence of the Registrant was to be given more weight than the evidence of Professor Rana. The Committee accepted that [redacted] and had an effect upon his decision making. However, having regard to the Registrant's own evidence, the Committee was satisfied that the Registrant knew what he was doing at the time when he committed the misconduct.

116. Applying the guidance from paragraph 22.6 of the Guidance and the case of *Sun v General Medical Council*, the Committee was of the view that the [redacted] cannot be said to alter the character of the misconduct, excuse or exonerate it, particularly as the Committee found that the nature and character of the dishonesty was towards the higher end of the scale of seriousness. However, the evidence in relation to the [redacted] was a relevant mitigating factor, which the Committee would take into account, to be weighed with the other mitigating factors and balanced against the aggravating factors, set out above.

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 considered taking no further action as set out in paragraphs 21.3 to 21.8 of the Guidance. It concluded that there were no exceptional circumstances present that could justify taking no action in this case. It further considered that taking no further action was not proportionate, nor a sufficient outcome, given the seriousness of the case, which involved dishonesty, practising without insurance for over a year, and the public interest concerns.

119. The Committee 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.

120. The Committee had regard to the Guidance in relation to the imposition of conditions. 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*."

121. 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.

122. The Committee did not consider that the Registrant held deep-seated personality or attitudinal problems. However, the Committee was of the view that there were no identifiable areas in the Registrant's practice in need of assessment or retraining given the nature of the misconduct being dishonesty.

123. 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,

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

125. The Committee was of the view that if conditions were placed on the Registrant they would need to be relevant to the dishonesty. Given the Committee's findings at the impairment stage, the Registrant had insight and there were no clinical or patient safety concerns. The Committee was not satisfied that workable and practical conditions could be framed that would adequately address the misconduct found proven in this case.

126. Furthermore, the Committee determined that a conditions of practice order would not sufficiently mark the serious nature of the misconduct, nor address the public interest concerns identified in the Committee's finding of impairment (which was made solely on public interest grounds). The Committee was also not satisfied that adequate conditions could be devised which would be appropriate, proportionate, workable or measurable in this case.

127. 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, which indicate that a suspension may be appropriate, as follows:

Suspension (maximum 12 months)

128. *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.

129. The Committee was of the view that all of the factors listed in paragraph 21.29 were applicable, apart from factor e) which was not relevant in this case.

130. In relation to factor a), this was serious misconduct, where a lesser sanction was not sufficient, as set out above. In relation to b), the Committee was of the view that there was no evidence of current harmful deep-seated personality or attitudinal problems. In relation to c), there was no evidence of repetition of the behaviour since the Registrant self-reported the misconduct. In relation to d), the Committee was satisfied that the Registrant has developed insight and repetition was highly unlikely.

131. The Committee balanced the mitigating and aggravating factors in the case, and considered the principle of proportionality. It concluded that a suspension order was appropriate and would address the public interest concerns that it had

identified. A period of suspension would send a signal to the public and profession that such conduct was not acceptable. The Committee concluded that a suspension order would adequately mark the seriousness of the Registrant's conduct, promote and maintain public confidence in the profession and promote and maintain proper professional standards and conduct.

132. The Committee also considered the relevant part of the Guidance in relation to erasure, at paragraph 23.35. The Committee noted that this list of factors is not exhaustive, however many of the factors listed did not apply. The Committee was of the view that this case was more closely aligned with the factors indicating that a suspension may be appropriate in paragraph 21.29 than the factors indicating that erasure may be appropriate in paragraph 23.35.

133. Moreover, the Committee was not satisfied that the misconduct was fundamentally incompatible with continued registration when considering the significant mitigating factors in the case, including- the Registrant's insight, remediation and [redacted]. In light of the significant mitigating factors, the Committee was of the view that erasure would be a disproportionate outcome. It was not the only means of maintaining and promoting public confidence and standards and conduct in the profession. The Committee was also mindful of paragraph 21.37 of the Guidance and the case of *Bijl v GMC* (Privy Council Appeal No. 78 of 2000), which emphasised that a Committee should not feel it necessary to remove:

"…*an otherwise competent and useful [registrant] who presents no danger to the public in order to satisfy [public] demand for blame and punishment.*"

134. Accordingly, the Committee concluded that a period of suspension was the appropriate and proportionate sanction to impose in this case.

135. The Committee gave very careful consideration to the appropriate length of the order of suspension and determined that, having balanced the mitigating and aggravating factors against the public interest, it would be proportionate to suspend the Registrant for a period of nine months. The Committee was of the view that nine months was an appropriate and proportionate period of suspension to sufficiently mark the seriousness of the Registrant's conduct, to send a signal to the public and the profession that such conduct was not acceptable and to address the public interest concerns it had identified.

136. The Committee when considering the appropriate and proportionate length of suspension took into account the impact of a suspension upon the Registrant, as set out in his evidence to the Committee. It was understood that a lengthy suspension would have a detrimental effect on the Registrant's ability to earn his usual income as an Optometrist and he was the sole earner for his [redacted] and it empathised with his position. However, the Committee considered that this was outweighed by the need to impose a period of suspension that adequately met the public interest. The Committee was mindful of the principle

arising from *Bolton v Law Society,* as set out in paragraph 21.38 of the Guidance that,

""*The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is part of the price*."

137. In addition, the Committee was not satisfied that it was appropriate to take an aggregate approach, of taking into account the previous six month suspension imposed upon the Registrant's registration. That was in separate proceedings for misconduct, not being dealt with by this Committee. The Committee considered the misconduct that had been found proved in this case and determined, after balancing the aggravating and mitigating factors, that a nine month period of suspension would be the minimum period necessary to meet the wider public interest and sufficiently mark the misconduct. The Committee was satisfied that a nine months suspension struck the balance correctly between the public interest and the Registrant's interests.

138. 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.

139. However, the Committee is minded, in this instance, not to order a review hearing, as it considered that a review would serve little purpose. The Committee was persuaded by the points made by the Registrant in his submissions in relation to a review hearing, that given the Committee had been impressed with the extent of the remediation already undertaken, a review hearing was not necessary. The Committee bore in mind that it had found that repetition was highly unlikely, the Registrant had developed insight, and that the finding of impairment had been made solely on public interest grounds. The Committee considered that the only possible basis to direct a review would be in order to be reassured that the Registrant is fit to resume unrestricted practice. However, there had been no clinical concerns raised in this case, the Registrant had recently successful returned to practice after a six month suspension and he would need to maintain his CPD in any event.

140. The Committee therefore imposed a suspension order for a period of nine months, without a review hearing.

Immediate Order

141. Dr Graydon, on behalf of the Council, invited the Committee to impose an immediate order of suspension under Section 13I of the Opticians Act 1989. Dr Graydon submitted that the applicable ground to make such an order would be 'otherwise in the public interest'. Dr Graydon reminded the Committee that it had found that the Registrant was not a risk to the public and there had been a

finding of impairment on public interest grounds only, which was a significant finding to make.

142. Dr Graydon referred the Committee to its findings on impairment and how it had found the dishonesty to be at the higher end of the scale of seriousness. Dr Graydon highlighted that the Registrant's previous fitness to practise matter also involved dishonesty. Dr Graydon submitted that it was otherwise in the public interest to impose an immediate order of suspension to mark the seriousness of the Registrant's dishonesty and to uphold standards to be expected of an Optometrist in the Registrant's position.

143. Dr Graydon referred the Committee to the aggravating and mitigating factors that it had found in its sanction determination and submitted that the aggravating factors outweighed the mitigating factors, supporting that it was necessary to impose an interim order of suspension in the public interest.

144. The Registrant opposed the imposition of an immediate suspension order. He submitted that the nine month period of suspension in and of itself sufficiently marked the seriousness of the misconduct and there was no need to add to that by making an immediate order of suspension. The Registrant highlighted that there had been no complaints against him and no interim order had been applied for after he notified the Council of the matter. In the circumstances, he submitted that it was illogical for an immediate order to be imposed against him now. Furthermore, an immediate order would have a negative impact upon him as it would prevent him from earning a living over the next few weeks.

145. 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.

146. The Committee had regard to the statutory test, which required that an immediate order had to be necessary to protect members of the public, otherwise in the public interest or in the best interests of the Registrant. The Committee was mindful that necessity was the appropriate requirement and that being desirable to make an order was not sufficient.

147. Having considered the circumstances of this case, the Committee was not satisfied that there was any necessity for an immediate order to protect the public as there were no public safety concerns arising in this case.

148. In relation to whether an immediate order was otherwise in the public interest, the Committee considered that the public interest had been adequately marked by the nine month suspension order itself. Furthermore, an immediate order would have a negative impact on the Registrant and be disproportionate. The

Committee did not consider that it was in the interests of the Registrant to make an immediate order.

149. Therefore, the Committee was not satisfied that the statutory test had been met and decided in the circumstances not to impose an immediate suspension order.

Revocation of an interim order

150. There was no interim order to revoke.

Chair of the Committee: Jayne Wheat

Signature :  **Date: 10 May 2024**

Registrant: Mohammed Waheed Zada

Signature: Present via MS Teams **Date: 10 May 2024**

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.