General Optical Council

BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(24)25

AND

LOKESH PRABHAKAR (01-27897)

DETERMINATION OF A SUBSTANTIVE HEARING
5 – 13 December 2024

Committee Members:	Pamela Ormerod (Chair/Lay) Victoria Smith (Lay) Vivienne Geary (Lay) Kalpana Theophilus (Optometrist) Ewen MacMillan (Optometrist)
Legal adviser:	Aaminah Khan
Council Presenting Officer:	Louise Culleton
Registrant present/represented:	Yes and represented
Registrant representative:	Nicholas Hall
Hearings Officer:	Latanya Gordon
Facts found proved:	1, 2, 3, 4, 6, 7, 8
Facts not found proved:	None
Misconduct:	Found
Impairment:	Impaired
Sanction:	Suspension for nine months – (With Review)
Immediate order:	No

ALLEGATION (AS AMENDED)

The Council alleges that in relation to you, Mr Lokesh Prabhakar (01-27897), a registered optometrist, between 2017 and 2019:

1. *You recorded tonometry results for the patients and on the dates set out in Schedule A when:-*

   a. *In respect of patients 1, 2, 3, 9 and 12, tonometry had not been measured;*
   b. *In respect of patients 4, 5, 6, 8, 11, 18, 19 and 22 the tonometry results recorded did not correspond with the actual measurements obtained.*

2. *Your conduct as alleged at Allegation 1 was:*

   a. *misleading;*
   and/or
   b. *dishonest.*

3. *You did not record tonometry measurements for the following patients on the following dates, despite tonometry having been conducted:-*

   a. *Patient 7 on 06 April 2019;*
   b. *Patient 10 on 06 April 2019.*

4. *You pre-populated the records of cup to disc ('C:D') ratios for some or all of the Patients set out in Schedule B.*

5. ~~*Your conduct as alleged at Allegation 4 was:*~~

   ~~*a. misleading;*~~
   ~~*and/or*~~
   ~~*b. dishonest.*~~

6. *In relation to Patient 6, you failed to carry out an adequate examination and/or maintain an adequate standard of record-keeping, in that, you did not adequately investigate or address the reasons for the visual field loss found during the assessment of Patient 6 on 06 April 2019;*

7. *You failed to conduct and/or record a visual field assessment on the patients set out in Schedule C.*

8. *You failed to adequately advise and/or record advice to Patient 1 of how their ocular condition and/or refractive findings might impact their driving abilities at their appointment of 20 March 2019.*

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

Schedule A
Patient 1 on 20 March 2019;
Patient 2 on 26 March 2019;
Patient 3 on 26 March 2019;
Patient 4 on 6 April 2019;
Patient 5 on 6 April 2019;
Patient 6 on 6 April 2019;
Patient 8 on 6 April 2019;
Patient 9 on 6 April 2019;
Patient 11 on 2 April 2019;
Patient 12 on 2 April 2019;
Patient 18 on 11 April 2019;
Patient 19 on 11 April 2019;
Patient 22 on 11 April 2019.

Schedule B
Patient 1 on 20 March 2019;
Patient 3 on 26 March 2019;
Patient 4 on 6 April 2019;
Patient 5 on 6 April 2019;
Patient 6 on 6 April 2019;
Patient 7 on 6 April 2019;
Patient 8 on 6 April 2019;
Patient 9 on 6 April 2019;
Patient 10 on 6 April 2019;
Patient 11 on 2 April 2019;
Patient 12 on 2 April 2019.

Schedule C
~~*Patient 13 on 27 July 2017;*~~
~~*Patient 14 on 11 April 2019;*~~
~~*Patient 20 on 27 July 2017;*~~
Patient 23 on 27 July 2017.

1. The General Optical Council (the ‘Council’) applied to withdraw certain allegations as there was insufficient evidence, which was not objected to by the Registrant.
2. The Committee granted the Council’s application to amend the Allegation in this manner under Rule 46(20) of The General Optical Council (Fitness to Practise) Rules Order of Council 2013 (‘the Rules’), as it was satisfied that the amendment was appropriate in the circumstances and could be made without injustice. The application related to particular 5 and Schedule C (apart from Patient 23), of the Allegation which were struck through, as shown above.

DETERMINATION

Admissions in relation to the particulars of the allegation

3. The Registrant admitted particulars 1 (a and b), 2 (a and b), 3 (a and b) and 4 of the Allegation. The Committee Chair announced that these particulars had been found proved, by virtue of the Registrant’s admissions, pursuant to Rule 46(6) of the Rules.

4. The Registrant partially admitted particular 8, in that he admitted that he failed to record the advice that he gave to Patient 1 of how their ocular condition and/or refractive findings might impact their driving abilities at their appointment on 20 March 2019. However, the Registrant denied the allegation that he failed to give this advice to Patient 1. As this was only a partial admission to what was alleged in this particular, it was not announced that this had been found proved and accordingly, it remained for the Council to prove this particular as alleged.

5. The Committee proceeded to hear evidence in relation to the remaining particulars of the Allegation that were disputed by the Registrant, which were particulars 6, 7 and 8.

Background to the allegations

6. The Registrant registered with the Council as an optometrist on 24 February 2014. The Registrant completed a post graduate certificate in glaucoma at [redacted] University in 2015. Between February 2015 and April 2019, the Registrant worked as a locum Optometrist with ASDA opticians.

7. Concerns were raised in March and April 2019, regarding the Registrant’s recording of tonometry results, by his colleagues (optical assistants) at the Branch A store of ASDA Opticians. At this store, the colleague would ordinarily complete the pre-screening tests and the results would be printed and handed to the Optometrist.

8. The concerns raised by the optical colleagues undertaking the pre-screening tests were that the measurements for the intraocular pressures (‘IOP’) recorded by the Registrant into the patient records did not correspond with the actual results obtained during pre-screening. This included occasions when no IOP

results had been obtained and yet measurements were recorded by the Registrant, as well as when measurements had been obtained and what was recorded by the Registrant was different.

9. When this was first noticed, an optical colleague of the Registrant's monitored the situation during a shift on 6 April 2019, by printing out two copies of the pre-screening tests, one of which was handed to him and the other was retained by the colleague in order to check against the Registrant's record keeping. It was noted that the Registrant had not recorded IOPs accurately for patients throughout the shift and there were discrepancies between what had been recorded in the patient records and the IOPs that had been obtained in the pre-screening tests.

10. The concerns were then escalated within ASDA Opticians and an investigation was commenced. This included the review of the Registrant's practices at other stores that he had worked at. A decision was taken to suspend the Registrant from the ASDA locum database whilst the concerns were being investigated.

11. As part of the investigation, a meeting was held with the Registrant on 29 April 2019. At this meeting, the Registrant stated that he pre-populated the IOP fields in the patient record card before the patient came in and he would then change the record card if he had clinical reasons to do so. He accepted that the records were not accurate but said that it did not change the clinical picture as the pressures were normal. He said that he did this to save time and that the numbers were within 'normal' range clinically so there was no issue. He then accepted that the inaccurate recording could affect future diagnosis of the patient. He accepted that entering records in this way was to enter a 'false record'.

12. During the meeting on 29 April 2019, the Registrant was asked whether there was any other part of the patient records that he pre-populated and in response he stated that he pre-populated records of cup to disc ('C:D') ratios, but that he always amended these following the examination. The Council had originally alleged that to pre-populate the C:D ratios of patients was misleading and/or dishonest. However, this aspect of the case was withdrawn during the hearing by the Council's application to amend the Allegation, on the basis that, unlike the tonometry measurements, the Council was unable to prove that the C:D ratios recorded by the Registrant were incorrect, as there were no comparator data or fundus images available.

13. ASDA decided that the Registrant would not be reinstated to its locum database and referred the Registrant to the Council on 2 May 2019.

The hearing

14. The Committee was provided with bundles of documentary evidence on behalf of both parties, which were supplemented with additional material as the hearing progressed. The documents included, but were not limited to, the witness statements of the ASDA witnesses, ASDA Standard Operating Procedures, records relating to the local investigation, ASDA Opticians patient records at the two branches concerned and screenprints from the Optix system (a patient management system) for the patients who were the subject of the Allegation, and the expert report of Dr Rakhee Shah.

15. The Registrant provided the Committee with two witness statements prepared during the course of these proceedings. The Committee also had before it the Registrant's initial response that he had provided to the Case Examiners.

16. The Council relied upon witness and documentary evidence from ASDA from Witness A, Optical Manager, Witness B, Compliance Manager, Witness C, ASDA Opticians Superintendent and Witness D, store People Manager. Of those witnesses Witness A and Witness B were called to give oral evidence. Witness C and Witness D were not required to attend to give oral evidence, as their evidence was not in dispute and they were not required to attend for cross-examination. Nor did the Committee require their attendance.

17. In addition to the above factual witnesses, the Council relied upon the expert evidence of Dr Shah, which was set out in her expert report dated 12 September 2022 and in more recent correspondence, sent in response to the Registrant's further witness statement. Dr Shah gave live evidence on the second and third days of the hearing.

18. Particulars 6, 7 and 8 of the Allegation arise from criticisms made by Dr Shah in her expert report, regarding the Registrant's alleged failures to either adequately examine, and/or maintain an adequate standard of record-keeping, in relation to discrete issues including visual field testing, or to adequately advise and/or record regarding driving abilities, in respect of three specific patients (respectively Patient 6 in an examination on 6 April 2019, Patient 23 in an examination on 27 July 2017 and Patient 1 in an examination on 20 March 2019).

19. The Registrant gave evidence on the third day of the hearing and was questioned by Ms Culleton, on behalf of the Council, his own representative Mr Hall, and the Committee.

20. In summary, the Registrant's evidence in relation to the three particulars that remained in dispute was that in respect of Patient 6, whom he examined in April 2019, was that Patient 6 had a documented visual field defect, which is a pre-existing condition, namely the scarring from laser treatment two years prior. In addition, the Registrant's evidence was that he noted that the patient was being monitored by the Hospital Eye Service ('HES'), with the next appointment scheduled within two months of the examination with the Registrant. He had been

provided with the visual field plots that showed defects in both eyes. The Registrant stated that in these circumstances he determined that repeating the visual field test was not clinically necessary, as the defects were expected because of the laser scarring and in any event the patient was already under HES care. In his evidence, the Registrant also highlighted that the visual field test that had been conducted demonstrated low reliability from fixation loss and this made it difficult to draw definitive conclusions from it.

21. The Registrant's case in relation to particular 7 was that he did not conduct a visual field assessment, as it was not clinically indicated for Patient 23. In his evidence he highlighted that whilst the patient was over 40, there was no documented family history of glaucoma and the clinical signs that he observed, including a C:D ratio of 0.65 and visible lamina cribrosa were in his view normal. The Registrant did not agree with the evidence of Dr Shah that these signs indicated that a visual field assessment should be conducted. The Registrant stated that there was no need for a visual field assessment as the NRR (neuro retinal rim) was healthy, the Inferior Superior Nasal Temporal (ISNT) evaluation rule obeyed indicating that in his opinion the discs were normal and tonometry was normal. However, upon reflection and consideration of the College of Optometrists guidance for professional practice, the Registrant accepted that he ought to have conducted a visual field assessment.

22. During his evidence the Registrant stated that Dr Shah had referred to there being no fundus picture, but the Registrant stated that he recalled having viewed the image of the optic nerve and confirmed it was healthy. Ms Culleton, on behalf of the Council, referred to the agreed witness evidence of Witness C, in which she stated that there were no fundus images for any of the patients available, as the stores did not have a fundus camera at that time. The Registrant indicated that if that was what Witness C's evidence was he was not disagreeing with it as he could not recall as it was over six years ago.

23. In relation to particular 8, the Registrant gave evidence that he advised the patient that they must drive with their prescription, but he did not explicitly record this advice in the record, as the patient was already aware of the need to wear their glasses full time and appeared to be 'compliant'. The Registrant's evidence was that he generally would only document "made aware of DVLA standards" in cases where the patient was non-compliant with wearing glasses for driving or if they were receiving a prescription for the first time, which he stated was not the case with this patient. While he indicated that he did not have a clear memory of the conversation, he relied on the statement that had been taken from Patient 1, in which they had stated that "the whole experience was very good, with each stage being explained fully." The Registrant stated that this supported that he had advised the patient fully.

24. The Committee heard closing submissions from the parties on the third day of the hearing. Ms Culleton reminded the Committee of her opening note and detailed opening submissions, which she invited it to have regard to. Ms Culleton highlighted the admissions that the Registrant had made and that the only

particulars that remained in dispute were 6, 7 and 8 (as it relates to whether the advice regarding driving was given). Ms Culleton submitted that to prove these allegations the Council primarily relied upon the expert evidence of Dr Shah, as to what the Registrant should have done in the particular circumstances before him.

25. Ms Culleton stated that the Council's case had changed a little in respect of particular 7, in that the allegation no longer relied upon there being a family history of glaucoma, but was instead based upon the other clinical findings, which meant that a visual field test for patient 23 was indicated.

26. Ms Culleton reminded the Committee that it ought to treat expert evidence like any other and it could accept or reject it. However, the Registrant had not called his own expert evidence to oppose or counter the expert evidence of Dr Shah and in those circumstances, Ms Culleton submitted, the Committee could and should rely upon Dr Shah's opinion, including on what a reasonably competent Optometrist would have done in the circumstances.

27. In Mr Hall's closing submissions, he submitted that in relation to discrete issues that were in dispute, the Council had not proved the allegations on a balance of probabilities. Mr Hall reminded the Committee that it had before it two witness statements of the Registrant, as well as his oral evidence. In relation to particular 7, Mr Hall submitted that whilst it may have been the Registrant's evidence on reflection that he ought to have done a visual fields test, it was still his case that he was under no professional duty to have conducted one at the time.

28. In relation to particular 8, Mr Hall submitted that the Council could have resolved this issue by calling evidence from Patient 1, as to what they were told by the Registrant and to clarify if she was wearing spare glasses, whether she was driving at the time etc, but they had not done so. Mr Hall stated that the Council was relying upon the fact that if the advice was not recorded, it was not given. However, Mr Hall submitted, the reality is that many things are discussed, advised and unfortunately not always recorded. The Registrant has admitted that he failed to record the advice given. It relation to the advice itself, this was obvious advice to have given to the patient and it was not sufficient to prove the allegation to rely upon the fact that the advice was not recorded.

29. The Committee heard and accepted advice from the Legal Adviser at the end of the facts stage, which included advice that the burden of proof throughout lies on the Council to prove, on the balance of probabilities, each of the facts alleged in the Allegation. In relation to the particulars of the Allegation that refer to an alleged failure upon the Registrant, the Committee was advised that it should firstly consider whether a duty or obligation exists upon the Registrant to act in that manner, before going on to consider if the failure is established.

30. The Legal Adviser advised the Committee that it should consider the expert evidence as part of the evidence as a whole, taking it into consideration when determining the facts in dispute. She advised that the role of the expert is to assist

the Committee on specialist or technical matters which are within that expert's area of expertise and to assist the Committee on matters that are outside of its experience and knowledge. The Committee is not bound to accept expert opinion, even where there is no contrary expert, however, there ought to be clear reasons to reject it, which ought to be set out in the determination if that is the case.

Findings in relation to the facts

31. The Committee considered all of the evidence in this case, including the documentary evidence, the evidence of Witness A, Witness B, and the uncontested evidence of Witness C and Witness D, the evidence of the expert witness Dr Shah and that of the Registrant. The Committee also considered the submissions from the parties.

Particular 6 – Patient 6

32. This particular of the Allegation relates to an alleged failure of the Registrant to carry out an adequate examination and/or maintain an adequate standard of record-keeping, by not adequately investigating or addressing the reasons for the visual field loss found during the assessment of Patient 6 on 6 April 2019.

33. The Committee firstly considered whether there was a requirement or duty for the Registrant to have carried out an adequate examination and/or to maintain an adequate standard of record-keeping, and it was satisfied that these are fundamental requirements that are placed upon Optometrists, as set out in the Council's standards, as well as the College of Optometrists Guidance for professional practice, as referred to in Dr Shah's expert report. The Committee was satisfied that the Registrant was under these duties, regardless of whether there was a forthcoming HES appointment for the patient.

34. The Committee went on to consider whether the Registrant failed to carry out an adequate examination, and/or to maintain an adequate standard of record-keeping, in the circumstances as alleged.

35. The Committee considered the Registrant's case, as set out in his witness statements and his live evidence, that the clinical signs were normal and that there was no clinical benefit, to repeating the visual field test. The Committee considered that it was significant that the defects from the visual field test were unreliable, and that the Registrant accepted that no conclusion could be drawn from them. This in the Committee's view, supported that they ought to have been repeated. This was particularly so for the left eye which appeared to have greater field defects but less observed retinal scarring than for the right eye. As the Registrant did not repeat the test, it was not known what visual field loss was present and whether or not it was due to the patient having difficulty when undertaking the visual field test ('poor fixation'), or due to other pathological factors.

36. The Registrant had concluded that the defects in the visual field test results were due to the scarring from the Patient's laser eye surgery two years earlier. However, this did not in the Committee's view adequately explain the results, particularly given the issues raised by Dr Shah regarding the location of the scarring not corresponding with the location of the defects.

37. The Committee had regard to the expert opinion of Dr Shah, who was of the view that the test should have been repeated by the Registrant based upon the clinical signs. The Committee considered that Dr Shah had given clear, considered and reliable evidence and it accepted her expert opinion that the clinical picture indicated that the visual field test ought to have been repeated by the Registrant. Where the Registrant's evidence differed, on the significance of the clinical signs and whether a re-assessment was indicated, the Committee preferred the expert evidence of Dr Shah over that of the Registrant.

38. At Paragraph 1.6 of Dr Shah's report she states –

"Visual field test was conducted, and the results are included in the bundle. Several points were not seen suggestive of a visual field defect. This test was not repeated to establish whether it is a true and consistent visual field and was not addressed in the patient management. On ophthalmoscopy, the RE was noted to have scarring in all quadrants and inferiorly in the LE. If the visual field loss found during the visual field test was due to the laser treatment, the ophthalmoscopy findings recorded do not correspond to the pattern of visual field loss found.

IOP readings in the patients record

card: RE: 15,16,16,17 Av 16LE:

16,13,13,12 Av 13.5

The results slip from the pre-screening for "Patient 6" is included on page 20 with a tonometry reading as below:

RE: 13,13,13,11 Av 16
LE: 13,12,13 Av 12.5

Overall, not further investigating and addressing the reasons for the visual field loss may have impacted the patient care. A referral is indicated if the field loss is repeatable and/or reasons for field loss unclear.

The patient care and management may have been affected if these unequal IOPs are assessed in combination with the risk factors (age and diabetes)

and visual field loss noted. Recording inaccurate IOP readings might also prevent the optometrist from making accurate management decisions in the future".

39. The Committee noted that the Registrant could have asked an optical colleague to have repeated the visual field test after his examination. He did not appear to have been under any particular time pressure, or other circumstances, that would have prevented the test from being easily carried out.

40. The Committee considered the Registrant's argument that this patient was under the care of HES with an appointment pending and there was no need for him to do anything further to investigate the issue. This position was not accepted by the expert witness Dr Shah, who had stated that the Registrant ought to have written a letter of information to the HES to inform them of the abnormal results. The Committee concluded that as it was not clear what was causing the visual field loss defects and whether this was an issue being dealt with by HES, the Registrant ought to have investigated the reasons for the visual field loss further, by, as a minimum, repeating the visual field test.

41. The Committee was satisfied on the evidence before it, that the Registrant had not carried out an adequate examination of Patient 6 in the circumstances. In addition, in relation to the Registrant's record-keeping, the Committee noted that the Registrant had recorded that the results of the completed visual field test were normal, when there were defects indicated on the printout, therefore the Registrant's record-keeping in relation to this issue was not accurate. The Registrant had stated that the images would be attached, however the Committee considered that this would create a confusing clinical picture of the patient's records for colleagues to follow at future appointments. The Committee took the view that in the circumstances, the Registrant did not maintain an adequate standard of record-keeping in relation to Patient 6's visual field loss found during the assessment.

42. Accordingly, the Committee found Particular 6 proved.

<u>Particular 7 – Patient 23</u>

43. This particular of the Allegation relates to an alleged failure of the Registrant to conduct and/or record a visual field assessment on Patient 23, at an appointment that took place on 27 July 2017.

44. The Committee noted that this patient had been requested by their GP to attend an eye examination for their blurred distance vision symptoms. The patient was

43 years old and under ASDA Optician's Standard Operating Procedure ('SOP'), a visual field test ought to have been conducted routinely as part of the pre-screening tests carried out by the Registrant's optical colleagues. No visual field assessment was recorded in the notes and the Council's case was that the Registrant ought to have ensured that one was conducted. The Registrant had accepted during the hearing that as an Optometrist, he was responsible for the delegated functions being performed when required.

45. The Council's case had initially been predicated upon there being a family history of glaucoma, however it was conceded during the hearing that there was no family history of glaucoma present. It was the Council's case at the conclusion of the fact stage that in relation to Patient 23, a visual field test ought to have been conducted in any event, due to the other clinical findings, which strongly indicated that a visual field test ought to have been conducted, relying upon the expert evidence of Dr Shah.

46. The Committee considered whether in the circumstances there was a duty or obligation upon the Registrant to have conducted a visual field assessment upon Patient 23.

47. The Committee considered the Registrant's case on this issue. Whilst he accepted what ASDA's SOP stated about conducting visual field assessments on all patients over 40, he stated that this was not routinely complied with and suggested that it would be difficult to do so. The Committee had regard to how during the Registrant's evidence, after being taken to the College of Optometrists guidance, he accepted that upon reflection he ought to have conducted a visual field assessment on Patient 23.

48. The Committee accepted the evidence of Dr Shah that the clinical signs, which included the age of the patient and the C:D ratio being higher than typically, indicated that a visual field assessment ought to have been conducted. This view was supported by ASDA's SOP, the College of Optometrists guidance for professional practice and the fact that the patient attended for a test under an NHS contract. The Committee considered that there was evidence in the record that the Registrant had evaluated the patient's optic nerve head which he concluded was normal. However, on balance he ought to have concluded, particularly as the C:D ratio was on the higher side, in all the circumstances, that the visual field assessment ought to have been carried out.

49. Where the Registrant's evidence differed, on the significance of the clinical signs and whether an assessment was indicated, the Committee preferred the expert evidence of Dr Shah over that of the Registrant. The Committee noted that in relation to this patient, the Registrant had said during his evidence that he had seen the fundus images, however he then accepted when the agreed evidence of Witness C was referred to him, that he may not have done and his recollection may have been mistaken about this. In the Committee's view, this affected the reliability of the Registrant's recollection of events.

50. The Committee in concluding that there was such a requirement upon the Registrant to have carried out the assessment had regard to Dr Shah's expert opinion and in particular, her view that as this was a first time patient, baseline measures ought to have been taken in order to be able to monitor changes in future, which would be important for patient care.

51. Considering all of the above, the Committee was satisfied that the Registrant ought to have conducted a visual field assessment upon Patient 23, as this would have been conducted by a reasonably competent Optometrist in the circumstances and he failed to do so.

52. Accordingly, the Committee found Particular 7 proved.

Particular 8 – Patient 1

53. This particular of the Allegation relates to an alleged failure of the Registrant to adequately advise Patient 1 of how their ocular condition and/or refractive findings might impact their driving abilities at their appointment on 20 March 2019.

54. The Committee was satisfied that there was a requirement upon the Registrant to have adequately advised Patient 1 of these matters, particularly as they had a spectacle prescription which, the Registrant and the expert agreed, would require glasses to be worn for in order for Patient 1 to meet driving standards. Furthermore, the notes made by the Registrant in the patient records indicated that the patient had lost their glasses a year ago and they had not been replaced. However, there was a reference to a reduced prescription to be dispensed to ease adaptation, but there were no details of this reduction. There was no entry in the patient records of what was discussed by the Registrant and the patient regarding the lost glasses, and any advice given by the Registrant to the patient about the requirement to wear glasses for driving. This had given rise to the concern of Dr Shah that Patient 1 may have been driving without glasses, which would pose a risk to both themselves and the public.

55. The Committee considered the Registrant's evidence, which was that he gave the appropriate advice but failed to record it. The Committee noted that the Registrant had no memory of this appointment, given that it was six years ago, and was relying upon his usual practice and the patient's note regarding her satisfaction with explanations given at the appointment. When asked questions by the Committee, the Registrant had accepted that if the patient had been wearing a spare pair of glasses, he would have recorded that prescription in the records. As he did not do so, he agreed that it could be inferred that she did not present with backup glasses, which appeared to contradict his assertion that she was a full-time wearer and at all times compliant.

56. The Committee took the view that the Registrant's account of this appointment was vague and not reliable, as he had no memory of it, he had not recorded the advice and he was making assumptions based upon the notes that he had made. The Committee also considered that the Registrant's account was confused, for

example, he had said he would usually only document his advice about driving where the patient was not compliant, but this was not on the information available, a compliant patient, as she had not replaced glasses broken a year earlier, with no indication that she had worn spare glasses. The Committee noted the point made by the Registrant that the patient was happy with the full advice given, however it considered that a patient would not necessarily appreciate if adequate advice had not been given to them, as they may not know what the advice should be.

57. In the circumstances and based upon the evidence before it, including the fact that the Registrant did not record any advice to the patient regarding driving, when she had not been compliant with wearing glasses, the Committee was satisfied that it was reasonable to draw an inference that it was more likely than not that the Registrant had failed to adequately advise Patient 1 of how their ocular condition and/or refractive findings might impact their driving abilities, at their appointment on 20 March 2019.

58. Accordingly, the Committee found particular 8 proved.

Misconduct

59. The Committee went on to consider, pursuant to Rule 46(12) of the Rules, whether the facts found proved amounted to misconduct.

60. The Committee heard submissions from Ms Culleton, on behalf of the Council, and from Mr Hall, on behalf of the Registrant.

61. The Committee received further documentation from the parties at this stage of the hearing. On behalf of the Registrant, the Committee had before it a stage two bundle, which included, but was not limited to, the Registrant's reflective statements, Continued Professional Development (CPD) Records and references. On behalf of the Council, the Committee was provided with copies of email correspondence from the expert Dr Shah regarding misconduct and her comments on the Registrant's remediation.

62. Ms Culleton invited the Committee to find that the facts admitted by the Registrant and/or found proved amounted to misconduct. She reminded the Committee that misconduct was a matter for the Committee's own judgement and that there was no standard or burden of proof to be applied at this stage.

63. Ms Culleton referred the Committee to the case law on misconduct, including the case of *Roylance v General Medical Council (No.2)* [2000] 1 A.C. 311, where, at paragraph 35, Lord Clyde stated:

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

standards ordinarily required to be followed in the particular circumstances."

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

- *5.3 Be aware of current good practice, taking into account relevant developments in clinical research, and apply this to the care you provide.*
- *Standard 7: Conduct appropriate assessments, examinations, treatments and referrals.*
- *7.1 Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs or cultural factors.*
- *7.2 Provide or arrange any further examinations, advice, investigations or treatment if required for your patient. This should be done in a timescale that does not compromise patient safety and care.*
- *Standard 8: Maintain adequate patient records.*
- *8.1 Maintain clear, legible and contemporaneous patient records which are accessible for all those involved in the patient's care.*
- *8.2.4 As a minimum, record the following information: The details and findings of any assessment or examination conducted.*
- *Standard 16: Be honest and trustworthy*
- *16.1 Act with honesty and integrity to maintain public trust and confidence in your profession.*

65. Ms Culleton reminded the Committee that the falling short of the standards must be serious, and the term serious must be given its proper weight and had been regarded in caselaw as conduct that was deplorable. Ms Culleton suggested that a helpful approach may be for the Committee to consider if the conduct found proved was a falling short, which was serious and which was deplorable.

66. Ms Culleton submitted that whilst misconduct was a matter entirely for the Committee's judgment, it was an area where expert evidence could assist and she referred the Committee to the views of Dr Shah on seriousness and whether conduct fell below or far below the standards expected, as set out in her expert report and the email correspondence sent during the hearing.

67. Ms Culleton highlighted Dr Shah's view that in relation to particulars 1-3, regarding the recording of the tonometry results, this conduct fell far below the

standards expected, as inaccurate or fictitious results may affect the proper management of patients in the future, including their patient care. As a result, the Council submitted that these amounted to serious misconduct. In any event, in relation to the dishonesty finding, Ms Culleton submitted that dishonesty was always a serious matter as it calls into question the Registrant's integrity, trustworthiness and honesty and was almost always capable of amounting to misconduct.

68. Ms Culleton acknowledged that in relation to particulars 4, 6 and 7, Dr Shah was of the view that these fell below, rather than far below, the standards expected and the Committee will want to take that into consideration. In relation to particular 8, this in Dr Shah's view also fell far below the standards expected, for the reasons set out in her email. Ms Culleton submitted that the Committee can and should find misconduct in relation to particulars 1, 2, 3 and 8. Ms Culleton invited the Committee to take into account Dr Shah's opinion and the standards and to find that misconduct is established.

69. Mr Hall, on behalf of the Registrant, invited the Committee to look at each particular of the Allegation individually, to see whether it constituted misconduct, which was serious.

70. Mr Hall submitted that whilst the Committee may be assisted by Dr Shah's evidence on the issue, ultimately, it was a decision for the Committee. Mr Hall stated that the Registrant accepted that particulars 1 and 2 constituted misconduct. However, he submitted that it was a matter for the Committee as to whether particulars 3, 4, 6, 7 and 8 amount to misconduct.

71. In relation to particular 3, Mr Hall highlighted that this was two instances of the Registrant not recording results when the tests had been done. There was no dishonesty attached in the Allegation, as there was for particular 1. In relation to particulars 4, 6 and 7, Mr Hall submitted that these were not misconduct, as whilst below the standards expected, the conduct did not fall far below. He submitted that this conduct was not sufficiently serious or deplorable as to amount to misconduct.

72. In relation to particular 8, Mr Hall submitted that the Committee might consider this to be a single incident of failing to advise. He stated that it could not be definitively said that Patient 1 was driving without glasses prior to the appointment, nor that they went on to drive without glasses due to the lack of advice given.

73. The Committee heard and accepted the advice of the Legal Adviser, who advised that the threshold of serious misconduct has been described in the case of *Meadow v GMC* [2007] 2 QB 462 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 held in the case of *Preiss v General Dental Council* [2001] 1 WLR 1296).

74. 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.

75. The Legal Adviser also 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 in relation to several Patients was that the Registrant's failings fell below, but not seriously or far below, the standards expected. The Legal Adviser 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, that approach has to be taken with caution following the more recent case of *Ahmedsowida v The General Medical Council* [2021] EWHC 3466 (Admin), which set out that cumulation was only permissible, if at all, in specific and limited circumstances. Further, it ought to be clear to the Registrant that a cumulative approach was being sought, which had not been done in this case.

76. The parties broadly agreed with the Legal Adviser's advice on the issue of cumulation and Ms Culleton, on behalf of the Council, made clear that the Council was not seeking that a cumulative approach to findings of misconduct be taken in this case.

The Committee's Findings on Misconduct

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

78. The Committee considered the "*Council's Standards of Practice for Optometrists and Dispensing Opticians*" and the standards which it had been referred to by the Council, namely 5 (keep your knowledge and skills up to date), 7 (conduct appropriate assessments etc), 8 (adequate record-keeping) and 16 (be honest and trustworthy), which the Committee was satisfied applied in this case.

79. The Committee also considered that the following standards applied, 17 (Do not damage the reputation of your profession through your conduct), 10 (work collaboratively with colleagues in the interests of patients) and specifically for particular 8, standard 2 (communicate effectively with your patients).

80. In relation to all particulars of the Allegation which had been admitted and/or found proved, the Committee was satisfied that there was a falling short by the Registrant of what was proper in the circumstances, with reference to the standards set out above. However, 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 therefore went on to consider whether the Registrant's failures were serious, in relation to each particular of the Allegation that had been admitted and/or found proved.

Particular 1 (a and b)

81. The Committee had regard to the expert evidence of Dr Shah and her opinion on seriousness, as set out in her expert report and her email correspondence sent to the Council during the hearing. In relation to the Registrant's conduct, which he admitted, of recording tonometry results for patients when it had not been measured (for 5 patients) and when the results recorded did not correspond to the actual measurements obtained (for 8 patients), Dr Shah was of the opinion that this conduct fell far below the standards to be expected of a reasonably competent Optometrist. Dr Shah considered that it was atypical and unlikely to be found in everyday practice, was unsafe, with both a potential risk to the patient and likely to bring the profession into disrepute.

82. Dr Shah set out in her report the potential implications for the patients concerned. For example, in relation to Patients 1, 2, 9 and 12, who did not have tonometry performed during pre-screening but for whom the Registrant had recorded results in the records, Dr Shah stated that,

"***4.1.1 Patient 1, 2,9 and 12.*** *These patients did not have tonometry performed during pre-screening. The recordings made in the records might form a baseline reading particularly if they are new to the practice. Recording inaccurate tonometry results that have not been measured is likely to have an impact on the future management of this patient and may put the patient at risk of visual field loss and/or for glaucoma."*

83. The Committee noted that given the ages of these patients, for at least two of them who were aged over 60, there was a significant risk that they my have had increased IOPs. The Committee was of the view that by recording false and inaccurate IOP results, this was a serious departure from the standards expected from a reasonably competent Optometrist (particularly standard 7.1 and 8.1) and what patients and colleagues would expect. In the Committee's view, the recording of accurate IOP measurements is particularly important, given the potential implications for patients should their IOP readings be raised and require further investigations, including for glaucoma.

84. The Committee agreed with the view of Dr Shah on the seriousness of this conduct, given the potential implications for patient care. The Committee was also satisfied that in the circumstances, the Registrant's actions were serious, would be considered wholly unacceptable and deplorable by fellow practitioners and amounted to misconduct.

85. Furthermore, the Committee noted that the Registrant had accepted the gravity of his conduct in his reflections and that Mr Hall, on his behalf, had acknowledged

that this aspect of the Allegation was sufficiently serious as to amount to misconduct.

86. Considering all of the above, the Committee was satisfied that the Registrant's conduct in particular 1 was serious and amounted to misconduct.

Particular 2 (a and b)

87. This particular relates to misleading and dishonesty. The Registrant had accepted that his actions were misleading and would give other colleagues a false impression of what had occurred in his eye examinations. Further, the Registrant had also admitted that this conduct was dishonest and had upon further reflection accepted the seriousness of his actions.

88. The Committee was satisfied that standards 16 and 17 were engaged by the Registrant's conduct, which fell far short of the standards of honesty and integrity to be expected in the profession. The Committee was of the view that it was also conduct that would bring the profession into disrepute and which professional colleagues would find deplorable. The Committee agreed with the submission made by Ms Culleton that generally dishonesty is serious and amounts to misconduct and it noted that Mr Hall had acknowledged in his submissions that this conduct amounted to misconduct.

89. Accordingly, the Committee found, having regard to all of the above matters, that the Registrant's conduct in relation to the tonometry results in 1a and b, was misleading and dishonest, was serious and amounted to misconduct.

Particular 3 (a and b)

90. The Committee considered the conduct found proved in Particular 3, which related to two patients for whom the Registrant was provided with tonometry measurements, after assessments were conducted, but were not entered on their patient records.

91. The Committee was satisfied that the standards set out above applied in this instance, including in particular standard 8 (adequate record keeping) and standard 10 (working collaboratively with colleagues). The Committee considered that standard 10 was engaged and had been breached by the Registrant not recording the results of the tonometry that his colleagues had carried out.

92. The Committee considered the submission made on behalf of the Registrant that this conduct was not sufficiently serious to amount to misconduct, as it related to failing to document tonometry results in relation to two patients.

93. The Committee had regard to the view of Dr Shah, which was that this conduct, as with failing to measure tonometry results and recording inaccurate results, fell far below the standards expected of a reasonably competent Optometrist. The

Committee was mindful that it was not bound to accept expert opinion if there is reason to not do so. However, in this case, in relation to Dr Shah's evidence on her assessment of seriousness and the potential implication for patients of the Registrant's conduct, it appeared to the Committee that there was no good reason to reject it.

94. Accordingly, the Committee was satisfied that the Registrant's conduct in particular 3 was serious and amounted to misconduct.

<u>Particular 4</u>

95. This particular was originally paired with particular 5, which alleged that the conduct in 4 (of pre-populating C:D ratios) was misleading and/or dishonest. The Committee was mindful that particular 5 was effectively withdrawn. This was due to insufficient evidence to support particular 5 because it was not possible for the Council to compare the records, with for example fundus images, to see if the pre-populated entries had been amended by the Registrant following the examination, as he had maintained. As a result, the conduct in 4 related solely to the pre-population of C:D ratios, with no dishonesty, or other opprobrium attached.

96. The Committee had regard to the view of Dr Shah, as contained in her email dated 10 December 2024, which was that,

"The Registrant has fallen below the standard of a reasonably competent optometrist for pre-populating the record card with the cup to disc ('C:D') ratios but amending them to reflect the ophthalmoscopy findings for some or all of the patients set out in Schedule B. Pre-populating the C/D ratios is atypical and unlikely to be found in everyday practice. It has the potential to risk patient safety and bring the profession into disrepute."

97. However, Dr Shah did not hold the view that the conduct in the circumstances fell far short of the standards expected. The Committee agreed with this assessment and was of the view that whilst pre-populating records was not good practice, this was not conduct capable of amounting to misconduct that was serious.

<u>Particular 6</u>

98. The Committee reminded itself that this conduct related to a failure to repeat a visual field assessment on a diabetic patient. The initial field plot which was handed to the Registrant showed defects, however he did not consider that it was clinically necessary to repeat it, which the Committee found was a failing as it preferred the evidence of Dr Shah over that of the Registrant. Dr Shah was of the view that the reason for the field loss in this patient was unclear. The recordkeeping aspect of this patient is that the Registrant recorded that the field test was normal when it was not. Whilst the field test plot would have been available as part of the patient records, the Committee found that this would have created a confusing clinical picture for future Optometrists examining the patient,

who would have to search beyond initial recorded findings to find the abnormal results.

99. The Committee considered that standards 7.1, 7.2, and 8 as a whole (as set out above) were breached by the Registrant's conduct. The Committee had regard to the expert view of Dr Shah, which was that this conduct fell below but not far below, the standards expected of a reasonably competent Optometrist. The Committee understood that view, however, considered it serious given that the Registrant had marked the results as normal, when in fact there were a number of visual field points missed, indicating a significant field defect. The Committee considered that by representing that this was a normal result within the records would be misleading for future reviews of those records. The Committee therefore, applying its own professional judgment of such matters, considered that in relation to the aspect of failing to maintain an adequate standard of record-keeping, the Registrant's conduct fell far short of the standards to be expected by a reasonably competent Optometrist.

100. Accordingly, the Committee was satisfied that the Registrant's conduct in particular 6 was serious and amounted to misconduct.

<u>Particular 7</u>

101. In relation to this patient (Patient 23), the failure was an isolated incident of failing to conduct and/or record a visual field assessment on this patient when the Committee found that one ought to have been conducted. There was not a negative outcome for the patient, with no evidence of harm or potential pathology.

102. The expert opinion of Dr Shah in relation to this patient is that the Registrant's conduct has fallen below the standard of a reasonably competent Optometrist, but as this is conduct that is unusual but not exceptional, with a potential risk to the patient, it is not conduct that falls far short of what is expected.

103. Whilst a falling short of the standards expected, the Committee did not consider that in the circumstances this was conduct which would be described as deplorable by fellow practitioners, nor sufficiently serious to amount to misconduct. The Committee agreed with Dr Shah's assessment of the seriousness of the breach.

104. Accordingly, the Committee was satisfied that the Registrant's conduct in particular 7 was not serious and did not amount to misconduct.

<u>Particular 8</u>

105. The Committee considered the Registrant's failure to advise (and record that advice) Patient 1 regarding how their ocular condition and/or refractive findings might impact their driving abilities, when they had stated that they had broken

their glasses a year earlier and not replaced them. The Committee considered that standard 2 was particularly relevant here, which requires that Optometrists communicate effectively with patients, who are given information in a way that they understand.

106. The Committee had regard to the view of Dr Shah, which was that the Registrant's conduct in relation to this patient had fallen far below the standard of a reasonably competent Optometrist for a failure to record and advise, as this conduct would be exceptional and unlikely to be found in everyday practice, with a risk of safety to the public and the wider public.

107. The Committee took the view that patients are reliant upon professionals to advise and guide them of risks, including advice to patients upon their prescription and when to wear their glasses. The patient in this case, on the evidence available, appeared to have been non-compliant with wearing glasses full-time, not having replaced them for a year and may not have appreciated the risks of driving without their glasses. Given the risk to the public and the patient themselves, if driving without glasses when they are required, the Committee agreed with the assessment of Dr Shah that the Registrant's failure to advise would fall far short of the standards to be expected of a reasonably competent Optometrist.

108. Accordingly, the Committee was satisfied that the Registrant's conduct in particular 8 was serious and amounted to misconduct.

109. The Committee found that the facts admitted and/or found proved do amount to misconduct, which was serious, in respect of particulars 1, 2, 3, 6 and 8.

Impairment

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

111. The Registrant gave further evidence at this stage of the hearing, under affirmation, which is summarised below. The Registrant was questioned on matters relevant to impairment by Mr Hall, Ms Culleton, and the Committee. At the stage of submissions, the Committee was provided by written submissions on impairment prepared by Mr Hall.

112. The Registrant confirmed that the evidence in his reflective statement, dated 1 December 2024, was correct. Mr Hall questioned the Registrant regarding what he had meant in his reflective statement when he had said that, "*I understand that a lack of knowledge is not a good enough defence, but I am trying to point out that I was not dishonest.*" The Registrant stated that he was trying to say that he knew he had made a serious error; based upon his then limited knowledge of the importance of IOP measurements he did not realise it was dishonest at the time. He stated that it was only through reflection and his remediation, that he come to

appreciate the gravity of his conduct. The Registrant stated that he was very sorry and was profoundly remorseful for his conduct. In addition, he was committed to ensuring that nothing like that happens again.

113. The Registrant explained that he had included a copy of the NICE Guidelines in his bundle to convey that he had misinterpreted the Guidelines where they state not to base decisions to refer on IOP measurements alone. Mr Hall questioned the Registrant on what he should have done differently in relation to the Allegations and why. The Registrant explained that in failing to record IOP measurements that had been taken (particular 3) this created a significant challenge for the next Optometrist reviewing the records and potentially put patients at risk. The Registrant gave evidence that he no longer pre-populated patient records because he now appreciated the risks of doing so. He described how he had changed his practice, including how he had improved his record-keeping, which was to a much better standard now.

114. The Registrant gave evidence regarding his current roles, how he had been supervised for approximately 3 years and how he saw his career developing in future.

115. Ms Culleton questioned the Registrant regarding when he had first realised that his conduct, in respect of the tonometry results, was wrong. The Registrant stated that this was when it was pointed out to him during the ASDA investigation meeting and that he later realised it was dishonest conduct after speaking to his legal team. Ms Culleton suggested to the Registrant that he had not given an honest account when first asked in that meeting about pre-populating records, which he accepted was due to it being the first time he had been asked about it and it took him some time to reflect upon the issue. He stated that he had however been truthful throughout the entire investigation. Ms Culleton suggested that the Registrant had changed his account several times throughout the interview, to which the Registrant accepted that he had given different accounts during that interview but after that it had remained the same for the past five years.

116. Ms Culleton questioned the Registrant regarding whether he knew his actions were dishonest and he responded that he did not know this at the time and had to reflect upon it, but accepted it was dishonest now. At the time he thought that there was no harm to patients and the conduct was not as bad as it was. He stated that over the past 6 years he had reflected, remediated and was now at the point that his professional judgment was sound.

117. Ms Culleton questioned the Registrant regarding the remediation and CPD that he had undertaken on honesty and integrity. The Registrant gave evidence that he did several courses on record keeping, which included the issue of honesty in the context of the importance of making accurate records. He also described the CPD modules that he completed on reflection and remediation.

118. The Committee asked questions of the Registrant including on what he had meant by saying that his decision making in respect of the recording of IOP

measurements was based on limited knowledge. The Registrant stated that his post-graduate course had increased his confidence in respect of contact tonometry but this had impacted his confidence in non-contact tonometry, in that it had devalued the importance of non-contact tonometry. The Registrant stated that he did not think about the importance of the IOP measurements to future Optometrists and was only thinking about the patient in the appointment before him.

The parties submissions on impairment

119. Ms Culleton, in her submissions on impairment, reminded the Committee that impairment was a matter for its professional judgement and there was no burden or standard of proof. She invited the Committee to consider the seriousness of the misconduct that had been found and whether the Registrant was currently fit to practise without restriction.

120.

121. In her submissions, Ms Culleton referred the Committee to 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. She submitted that limbs (a)-(d) of this test are all engaged in this case, namely conduct which put patients at unwarranted risk of harm, brings the profession into disrepute, conduct which breaches one of the fundamental tenets of the profession and dishonesty.

122. Ms Culleton invited the Committee to have regard to the evidence in the Registrant's bundle and the live evidence he gave today. She submitted that the Registrant's appreciation of dishonesty only appeared to have come about from his reflection, which the Committee may think was quite late in the day. Ms Culleton suggested that this shows a lack of insight, as the conduct was, in and of itself, dishonest, even if no concealment or other such factors were present. Ms Culleton suggested that the Committee may find it concerning that this was not appreciated by the Registrant.

123. Ms Culleton submitted that dishonesty is always considered to be a most serious matter, as it calls into question a Registrant's honesty, integrity, and trustworthiness and affects the reputation of the profession as a whole. Ms Culleton stated that patients rely upon Registrants being of the upmost standing. She submitted that honesty is a more inherent quality than clinical failings and less easy to remediate.

124. Ms Culleton reminded the Committee that it needed to have regard to the wider public interest when considering impairment. Although Mr Hall would make make reference to the case of *Sheikh v General Dental Council* [2007] EWHC 2972 in his submissions on impairment, Ms Culleton submitted that this case was not relevant at this stage, as it related to interim orders. She submitted that the case of *Grant* was the most relevant case to consider at this stage.

125. Ms Culleton referred to the availability of a warning being issued to the Registrant, if the committee was to make a finding of no impairment. She referred the Committee to the Hearings and Indicative Sanctions Guidance (revised November 2021) ('the HISG'), on this issue. However, she submitted that the Committee can and should properly conclude that the Registrant's fitness to practise is currently impaired.

126. Mr Hall, on behalf of the Registrant, invited the Committee to find that the Registrant was not impaired either on public protection or public interest grounds. Although the past conduct in the Allegations had been the focus of the hearing so far, Mr Hall invited the committee to assess the Registrant as of today, over five years since the conduct occurred. Mr Hall submitted that it would be an over-simplistic approach to say "we have dishonesty therefore we have impairment". He accepted that dishonesty is serious, but invited the committee to view dishonesty on a spectrum. Mr Hall submitted in this case that dishonesty fell on the lower end of the spectrum.

127. Mr Hall accepted that the case of *Sheikh* dealt with interim orders, but submitted that it was still relevant once public protection had been removed. He argued that there was still a high bar to impose a finding of impairment on public interest grounds alone. In any event, he submitted it was not necessary to make a finding of impairment on public interest grounds in this case.

128. Mr Hall submitted that the Registrant was not a risk to the public, highlighting the nature of the charges, which he described as reckless and careless, not for financial gain, but thoughtless, and stupid. Furthermore, he suggested the conduct stemmed from the Registrant's immaturity and, whilst it may have put patients at risk of harm, it thankfully did not cause any patients harm.

129. Mr Hall submitted that it was tempting to demand perfection regarding remediation, but here the reality was that the Registrant had improved his practice. He referred to Dr Slade's report which concluded that the Registrant was low risk, which was also reflected by Dr Shah's evidence in these proceedings. Mr Hall referred the Committee to the evidence from the Registrant's supervisor, who had no clinical concerns guarding the Registrant having supervised him for a period of three years. There had been no other concerns raised regarding the Registrant, who had practised throughout. Mr Hall reminded the committee of the character references in the Registrant's bundle and the extensive CPD that he had undertaken. Mr Hall questioned what more the Committee would want the Registrant to have done.

130. In relation to insight, Mr Hall submitted that the Registrant had demonstrated a high level of insight and had demonstrated remorse. He acknowledged that the Registrant was not the most upfront at the start of the investigation interview. However, he had made admissions and volunteered new information (regarding his then practice of pre-populating C:D ratios). The Registrant continued to admit wrongdoing and ultimately admitted dishonesty, for which he deserves credit.

131. Turning to the public interest, Mr Hall submitted that it was not necessary to make a finding of impairment in order to uphold the public interest, because it had already been upheld by going through these proceedings. A fully informed member of the public would not consider it necessary to make a finding of impairment in this case. Mr Hall submitted that it was also in the public interest to have a safe Optometrist in practice.

132. 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 and outlined the relevant considerations set out in the case of *Cohen v GMC* [2008] EWHC 581 (Admin), namely whether the conduct is remediable, whether it has been remedied, and whether it is likely to be repeated.

133. The Legal Adviser referred the Committee to the case of *GMC v Armstrong* [2021] EWHC 1658 (Admin), which sets out that dishonesty can arise in a variety of circumstances and in a range of seriousness and that Committees must have proper regard to the nature and extent of the dishonesty and engage with the weight of the public interest factors tending towards a finding of impairment. This case also sets out that, in cases of dishonesty, the impact on public confidence in the profession is not diminished by a low risk of repetition and that the Committee must consider the weight that it puts on personal mitigation as this may have a more limited role in cases of dishonesty. It also sets out that it is a rare or unusual case where dishonesty does not lead to a finding of impairment.

134. The Legal Adviser confirmed that she agreed with Ms Culleton's position that she was unaware of any legal authority which had extended the principle in *Sheikh* (of there being a high bar to make a finding on public interest grounds alone) from interim orders to the issue of impairment.

The Committee's findings on impairment

135. 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 HISG, the legal advice given by the Legal Adviser and its earlier findings.

136. 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.

137. The Committee noted that the misconduct which it had found related to clinical concerns, as well as conduct that was dishonest. The Committee had regard to the HISG, which at paragraph 16.1, states that:

'*Certain types of misconduct (for example, cases involving clinical issues) may be more capable of being remedied than others*.'

138. The Committee was of the view that the misconduct in this case which involved the clinical concerns was capable of being remedied. Whereas, the dishonesty was more difficult, albeit not impossible, to remediate.

139. The Committee turned to consider whether the Registrant's misconduct had been remedied by him since the events took place in 2019. The Committee noted the steps that the Registrant has taken in order to remediate, which include his reflective statements, working under supervision for approximately three years, with positive feedback, and the significant amount of CPD undertaken, including the various courses on topics including mastering record-keeping, reflection, remediation and how to ensure misconduct is not repeated. The Committee noted that the Registrant had completed various CPD courses that related to glaucoma and the number of hours of CPD completed by the Registrant consistently exceeded the level required.

140. In relation to the courses undertaken by the Registrant, the Committee noted that the Registrant appeared to rely upon courses which did not directly address dishonesty and/or integrity. However, the evidence of the Registrant was that this was covered in the record-keeping courses and CPD which emphasised the importance of maintaining accurate records. The Committee took the view that the Registrant's remediation, whilst adequate for the clinical concerns, needed to be fuller in respect of the dishonesty, for example by more targeted and interactive courses on honesty and integrity.

141. The Committee considered the level of insight demonstrated by the Registrant, in his written reflective statements and the oral evidence that he has given during this hearing. The Committee was of the view that he was able to reflect in his evidence upon why the clinical misconduct occurred and he gave examples of how he had improved his practice and/or would do matters differently.

142. However, the Committee considered that the Registrant could develop further insight into the dishonesty, which it considered was more limited than in relation to the clinical concerns. For example, the Committee considered that the Registrant's insight into his dishonesty was limited because he sought to blame its occurrence on a lack of knowledge of the importance of IOP measurements, which the Committee considered was an attempt to minimise the conduct.

143. Overall, the Committee found that the remediation undertaken by the Registrant does address the misconduct and was adequate in respect of the discrete clinical issues but took the view that the Registrant had not sufficiently remediated in respect of the dishonesty.

144. The Committee turned to consider the likelihood of repetition. The Committee had regard to the references from the Registrant's two work colleagues, as well as the positive comments from his supervisor. Although both references were

positive, the Committee noted that the Registrant's Optical Manager did not make reference to the Registrant's honesty and integrity, focusing upon record-keeping. The Committee noted that it was now over five years since the misconduct occurred and there had been no further concerns raised. In addition, as set out above, the Committee was of the view that the Registrant has reflected, developed some insight, and remediated his misconduct in relation to the clinical failings. Accordingly, the Committee determined that the Registrant's risk of repetition, in relation to the clinical failings, is low. However, in relation to dishonesty, as set out above, the Committee was of the view that given that the Registrant had not developed full insight or adequately remediated, there remained a risk of repetition in that respect.

145. Having regard to all of the above, the Committee determined that the Registrant's fitness to practise was not impaired on public protection grounds in respect of the clinical issues but was impaired on public protection grounds in respect of the dishonesty.

146. The Committee next 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 Ms Culleton that limbs (a)-(d) 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 and dishonesty. The Committee considered that these limbs of the test were engaged on the Registrant's past conduct in relation to the misconduct found proved, and on the basis of being '*liable in the future to so act*' in respect of the dishonesty, given that the Committee had found that there remained a risk of repetition in relation to that misconduct.

147. The Committee considered whether a finding of impairment was necessary on the basis of the wider public interest in order to uphold proper professional standards and public confidence in the profession.

148. The Committee considered the extent and seriousness of the Registrant's dishonesty in respect of the tonometry results. The Committee acknowledged that there was no financial gain linked to the conduct, however this was not an isolated incident. The Committee did not agree with Mr Hall's characterisation of the dishonesty as being careless, stupid or at the lower end of the scale. Nor did the Committee consider that the Registrant's age or level of maturity were relevant factors. In the Committee's view the dishonesty in this case was serious and systematic, involving multiple patients, and a breach of several standards. It also involved a significant disregard for patient care.

149. Furthermore, the Committee had regard to paragraph 17.1 of HISG, which states that,

"*Dishonesty is particularly serious as it may undermine confidence in the profession. Examples of dishonesty may include:*

Improperly amending or changing the detail on patient records."

150. The Committee was of the view that despite the remediation that had been undertaken by the Registrant, given the seriousness of the dishonesty, the public would be concerned and public confidence in the profession would be undermined, if a finding of impairment was not made, in respect of the Registrant's dishonest misconduct. The Committee determined that it was necessary to make a finding of impairment in this case in order to maintain confidence in the profession and in order to uphold proper professional standards.

151. Accordingly, the Committee found that the Registrant's fitness to practise as an Optometrist is currently impaired.

Sanction

152. The Committee went on to consider what would be the appropriate and proportionate sanction, if any, to impose in this case. It heard submissions on sanction from Ms Culleton, on behalf of the Council, and from Mr Hall, on behalf of the Registrant.

153. The Committee received further documentation at this stage of the hearing as follows. Mr Hall placed before the Committee his written submissions on sanction and the Council provided the Committee with a prior fitness to practise determination dated 1 February 2018, in which the Registrant was issued with a Warning for a period of 12 months. The Warning was issued for inadequate assessment and record-keeping concerning a contact lens patient.

154. In her submissions on sanction, Ms Culleton reminded the Committee that the appropriate sanction was a matter for the Committee's professional judgment. She emphasised that the purpose of imposing a sanction was not to punish the Registrant, although it may have a punitive effect. The primary purpose of sanctions was to protect the public. She invited the Committee to consider the least restrictive sanction first, with regard to the guidance set out in the HISG and to work through the hierarchy of sanctions stopping where it was proportionate to do so.

155. Ms Culleton submitted that the Committee was entitled to take into account, as aggravating factors, that the misconduct included dishonesty, the seriousness of it (highlighting the factors that the Committee had found at the impairment stage) and also the Registrant's fitness to practise history. In relation to the Registrant's Warning, Ms Culleton submitted that there were similarities both in the nature of the misconduct and also the mitigation that had been advanced, for example relying upon the Registrant's immaturity. She suggested that this may indicate a continued lack of insight.

156. Ms Culleton submitted that in light of the Committee's findings at the impairment stage, including that the clinical matters have been remediated and it was the dishonesty that was in issue, the Committee may consider that conditions would not be appropriate. Ms Culleton queried how conditions could address dishonesty and submitted that suspension may be the appropriate sanction. Furthermore, Ms Culleton highlighted that almost all of the factors set out at paragraph 21.29 of the HISG, which indicate when a suspension order might be appropriate, were met. Ms Culleton referred the Committee to the factors in HISG at paragraph 21.35 regarding erasure and submitted that the Council's position was that nothing less than a suspension would be appropriate.

157. Mr Hall, on behalf of the Registrant, submitted that conditions would strike the correct balance and would protect the public and allow the Registrant to continue to remediate whilst in practice. If the Committee did not agree, Mr Hall invited that it consider imposing a short period of suspension, at the lower end, for the following reasons: any further remediation could be completed in two to three months; these proceedings have been extremely delayed; there has been no repetition of concerns in the last five years; the Committee had recognised that the Registrant has remediated the clinical concerns and improved his practice; the Registrant was subject of an interim order of conditions for a period of three years; he has engaged in these proceedings; with regard to proportionality, a suspension would have a punitive effect upon the Registrant.

158. Mr Hall submitted that a period of suspension would mean that he would lose all income and would put an incredible emotional pressure upon the Registrant, would impact his partner and could lead to a loss of accommodation.

159. Mr Hall referred the Committee to the HISG and the sanctions available. He submitted that either conditions or a brief period of suspension would be appropriate. He acknowledged that the public interest was engaged and the seriousness of the dishonesty, but submitted that this needs to be weighed against the 6 factors highlighted above. Mr Hall submitted that if an informed member of the public knew those factors and that further remediation could be done in a short period they would not find it necessary for the Registrant to lose his job, especially in this economic climate.

160. Mr Hall submitted that appropriate conditions could relate to mentoring and further reflection, which would enable the Registrant to come to a review hearing and demonstrate how he has developed further insight and remediated fully. He accepted that a review hearing would be necessary.

161. 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.

The Committee's findings on sanction

162. 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. The Committee also had regard to its previous findings at the misconduct and impairment stages.

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

    a) The seriousness nature of the dishonesty (systematic, multiple patients and disregard for patient care) and the Registrant's limited insight into it;
    b) The Registrant's fitness to practise history, and the similarities in the conduct for which a Warning was issued (inadequate assessment and record-keeping) and the short interval between the Warning and the repetition of misconduct.

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

    a) The Committee's finding that the Registrant has undertaken adequate remediation in respect of the clinical failings.
    b) The Registrant made admissions, including those made in the investigatory meeting to pre-populating C:D ratios, which he volunteered himself.
    c) The passage of time since the most recent misconduct (over five years) during which time the Registrant has worked under supervision and fully engaged with these proceedings, with no further concerns raised.
    d) The Registrant had demonstrated dedication to the profession through development and further training.

165. The Committee considered the two testimonials that it had before it from the Registrant's work colleagues, however concluded that only limited weight could be attached to these given that they appeared to have been written without the authors having knowledge of the dishonesty and they contained no reference to having any knowledge of the Registrant's fitness to practise history.

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

167. The Committee considered taking no further action as set out in paragraphs 21.3 to 21.8 of the HISG. The Committee noted that to do so exceptional circumstances would be required and HISG states at paragraph 21.3 that,

    '*Where a registrant's fitness to practise is impaired, the FtPC would usually take action to protect patients, maintain public confidence in the profession and uphold proper standards of conduct and behaviour*.'

168. The Committee determined that there were no exceptional circumstances present that could justify taking no action in this case. It further considered that taking no further action would not be a proportionate, nor a sufficient outcome, given the seriousness of the case and the public interest concerns.

169. 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.

170. The Committee next considered the HISG 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."*

171. The Committee considered that for conditions to be appropriate and workable they would need to address the misconduct and any risks identified in the 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*."

172. The Committee was mindful that it had found that the Registrant had remediated the clinical concerns, but not fully remediated the dishonesty.

173. The Committee noted that the Registrant had complied well with his interim order of conditions. However, the Committee was of the view that at this time there did not appear to be identifiable clinical areas in the Registrant's current practice in need of assessment or retraining. The Committee considered that it would be difficult in this case to frame appropriate conditions to address the dishonesty and the Committee's concerns regarding insight into the same.

174. The Committee concluded that it would not be possible to formulate appropriate and practical conditions in this case, relevant to the misconduct of dishonesty.

175. Furthermore, the Committee determined that a conditional registration order would not sufficiently mark the serious nature of the misconduct, nor address the public interest concerns identified when making a finding of impairment. The Committee was also not satisfied that adequate conditions could be devised which would be appropriate, proportionate, workable or measurable in this case.

176. The Committee next considered suspension and had regard to paragraphs 21.29 to 21.31 of the HISG. 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)

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.*

177. The Committee was of the view that many of the factors listed in paragraph 21.29 were applicable, apart from factor e) which was not relevant in this case. In relation to factor a), this was serious misconduct, where a lesser sanction was not sufficient, as set out above.

178. In relation to b), the Committee was of the view that this factor applied to an extent. The Committee considered that dishonesty is likely attitudinal but was not satisfied that in this case it could be described as deep-seated. In relation to c), there was no evidence of repetition of the behaviour since the incidents.

179. In relation to d), the Committee was of the view that the Registrant has developed limited and recent insight, which minimises the risk of clinical repetition but requires further insight to ensure that the dishonesty is not repeated.

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

Erasure

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

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

181. The Committee considered that several of these factors also applied in this case, in particular a), b) f) and partially h).

182. However, the Committee balanced the mitigating and aggravating factors in the case and considered the principle of proportionality. Whilst several of the factors indicating erasure were present in this case, on balance the Committee did not conclude that the conduct was fundamentally incompatible with continued registration. The Committee did not consider that erasure was the only order that would protect the public and was of the view that erasure would be disproportionate and unnecessarily punitive in this case.

183. The Committee therefore concluded that a suspension order was appropriate in order to address the public interest concerns that it had identified. A period of suspension would send a clear 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.

184. The Committee was mindful of the impact of a suspension upon the Registrant, as outlined by Mr Hall, including restricting the Registrant's ability to earn an income as an Optometrist, which would inevitably cause stress and a loss of income to the Registrant. However, the Committee was satisfied that having regard to the seriousness of the misconduct, it struck the balance correctly between the public interest and the Registrant's interests.

185. In relation to the length of suspension, the Committee gave 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. When considering the appropriate length of order, the Committee had regard to the mitigation, the impact upon the Registrant and the fact that he had been subject to an interim order of conditions for a lengthy period. However, it also had regard to how the dishonesty related to patient records, was systematic and the Registrant has limited insight at this time into the dishonesty. If the period was shorter, the Registrant would not have sufficient time to reflect and remediate further.

186. In the circumstances, 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 message to the public and the profession that such conduct was not acceptable and to address the public interest concerns it had identified.

187. 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 HISG, 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.

188. The Committee bore in mind that it had found that there remained a risk of repetition of the conduct, as the Registrant had not developed full insight or adequately remediated in respect of the dishonesty. In the circumstances, the Committee was satisfied that it was appropriate to direct a review hearing before the order of suspension expired.

189. The Committee therefore imposed a suspension order for a period of nine months, with a review hearing to be held between four and six weeks prior to the expiration of this order. The Review Committee will need to be satisfied that the Registrant:

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

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

(i) Evidence of any further relevant CPD or other remediation undertaken, targeted at honesty and integrity in professional practice (not necessarily limited to Optometry). Interactive discussions with professionals may be of assistance.

(ii) Evidence of further reflection and development of insight, for example an updated reflective statement, including reflections on the learnings from further experiences, CPD and remediation undertaken.

Immediate Order

191. The Committee went on to consider whether to impose an immediate order of suspension and invited representations from the parties on this issue.

192. Ms Culleton, on behalf of the Council, invited the Committee to impose an immediate order of suspension under Section 13I of the Opticians Act 1989. She submitted that the applicable grounds to make such an order would be that it was necessary to protect the public and was 'otherwise in the public interest'. Ms Culleton submitted that making an immediate order would be consistent with the Committee's earlier findings and would cover the period of any appeal.

193. Mr Hall opposed the imposition of an immediate order and submitted that the nine month period of suspension in and of itself sufficiently marked the public interest. In relation to protecting the public, Mr Hall submitted that the reality was that the Registrant has been practising without further incident since the misconduct and had been working unsupervised for over a year. Mr Hall stated that if an immediate order was made, this would add on the 28 day appeal period, so that it would effectively be a 10 month suspension, which would not be proportionate. Not making an immediate order would also allow the Registrant time to get his affairs in order and not leave patients in the lurch from Monday onwards. Mr Hall stated that he could not bind the Registrant but indicated that an appeal was highly unlikely.

194. 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 advised that necessity had been described in caselaw as being more than desirable, but less than indispensable.

195. The Committee considered the statutory test and the parties submissions. The Committee was not satisfied that there was any necessity for an immediate order to protect the public as there were no public safety or clinical concerns regarding the Registrant. The Registrant had been working in the past five years with no further concerns raised against him, with no supervision over the past 12 months.

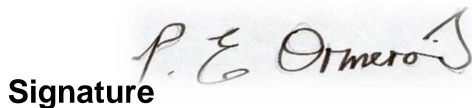
196. In relation to whether an immediate order was otherwise in the public interest, the Committee considered that the public interest had been adequately marked by the nine month suspension order itself. The Committee did not consider that it was in the interests of the Registrant to make an immediate order.

197. 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 interim orde

198. There is no interim order to revoke.

Chair of the Committee: Pamela Ormerod

Signature  **Date:** 13 December 2024

Registrant: Lokesh Prabhakar

Signature Present via Microsoft Teams **Date:** 13 December 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.