BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

AND

MR BRYAN AINLEY (01-7055)

DETERMINATION OF A SUBSTANTIVE HEARING
10-14 JUNE 2019

| Committee Members: | Ms V Paterson (Chair/Lay)  
|                    | Dr P Ormerod (Lay) 
|                    | Ms K King (Lay) 
|                    | Mr G Elliott (Optometrist) 
|                    | Ms S Nasrullah (Optometrist) |
| Legal adviser:    | Ms M Coutino |
| GOC Presenting Officer: | Mr M Corrie |
| Registrant present/represented: | No and not represented |
| Registrant representative: | N/A |
| Hearings Officer: | Mr T Chisango (10-14 June) 
|                    | Mr T Yates (14 June) |
| Facts found proved: | 1a-c, 2a-b, 3a-c, 3a-d, 4a-e, 5a-b, 7a-e, 9a-b, 11a-g, 13a-l, 15a-j, 16a, 17a-b, 18a-j, 20a-f, 23 and 24b-k. |
| Facts not found proved: | 4f-g, 6a-e, 8a, 10a-g, 12a-l, 14a-j, 16b, 19a-b, 21a-e, 22a-e. |
| Misconduct/DPP:   | Misconduct Found / DPP not found |
| Impairment:       | Impaired |
| Sanction:         | Erasure |
| Immediate order:  | Imposed |
Proof of service
The Committee heard an application from Mr Matthew Corrie for the Council for the matter to proceed in the Registrant’s absence. First, the Council was required to satisfy the Committee that the documents had been served in accordance with Section 23A of the Act and Rule 61 of the Fitness to Practise Rules 2013. The Committee accepted the advice of the Legal Adviser.

The Committee is satisfied that all reasonable efforts have been made to notify the Registrant of the hearing.

Proceeding in the absence of the Registrant
The Committee then went on to consider whether it would be in the public interest to proceed in the Registrant’s absence in accordance with Rule 22. The Committee accepted the advice of the Legal Adviser.

The Committee considered the circumstances of the case, the evidence before it and accepted the advice of the Legal Adviser. It applied the relevant tests as outlined in the case of the R v Jones, and R v Adeogba. Taking into account that:

a. Good service had been effected;

b. Emails had been sent on the Registrant’s behalf to acknowledge that paperwork had been sent but that he would not be present;

c. The Registrant had not asked for an adjournment, nor indicated a willingness to attend any future hearing, meaning an adjournment would serve no useful purpose.

The Committee determined that the Registrant had voluntarily absented himself waiving the right to attend. Further, the Committee found that it was in the interests of justice for matters to proceed in the absence of the Registrant or any representative on his behalf given that the matters alluded to in the Allegation dated back three years. It was in the interests of the public and the Registrant, along with the witnesses in the case, for matters to be concluded in a timely manner.

Application to amend the allegation
The GOC applied to amend allegations 4d) and 5b) in each instance substituting the number “18” with the number “17”. This was as a result of an error that had been made, and more accurately reflected the evidence before the Committee. The Committee agreed to amend the allegation, as no response to any allegation had been formally made, and this amendment which better reflected the evidence would not impact adversely upon the Registrant.

Further, the Committee was assisted by a Skeleton Argument provided on behalf of the Council and submissions made by Mr Corrie. The Committee was both persuaded by what it had heard, in relation to concessions made in relation to particular 8b of the Allegation meaning that there was insufficient evidence to find this proved, and that Particular 24a, was duplicitous, given the drafting of Particular
Accordingly, the Committee has struck Particular 8b and Particular 24a from the Allegation.

THE ALLEGATION (as amended)

The Council alleges that you, Bryan Ainley:

1. On 18 March 2016 you failed to obtain an adequate history of Patient A in that you did not obtain any or any adequate information as to:
   a. general health and/or
   b. medical history and/or
   c. family history.

2. On 18 March 2016 you failed to carry out an adequate examination of Patient A's fundus in that:
   a. You carried out a direct ophthalmoscopy looking only straight ahead and/or at a working distance of approximately 10cm;
   b. You carried out an indirect ophthalmoscopy with an angle-poise light.

3. On 18 March 2016 you failed to carry out an adequate assessment of Patient A's visual fields in that:
   a. You were unable, adequately or at all, to operate the testing equipment;
   b. You carried out the test without dimming the lighting in the room;
   c. You did not test Patient A's left eye.

4. On 18 March 2016 you did not make an adequate record of your appointment with Patient A in that:
   a. You failed to record, adequately or at all, Patient A's presenting symptoms and/or reason for attending for examination;
   b. You failed to adequately record the results of the visual fields test;
   c. You failed to record the time of day intraocular pressure was measured;
   d. You incorrectly recorded intraocular pressure in Patient A's right eye as 17;
   e. You failed to record adequate detail of the internal and/or external eye examination;
   f. You failed to record, adequately or at all, any advice given;
   g. You failed to record, adequately or at all, any conclusions reached from the examination.

5. On 18 March 2016 you made an inaccurate record of your appointment with Patient A in that:
a. You recorded a dash to indicate that a visual fields test had been carried out on Patient A's left eye when it had not;

b. You recorded intra ocular eye pressure as 17 for both of Patient A's eyes when you had only measured the right eye;

6. You failed to make any, or any adequate enquiry of the current visual status:

   a. In relation to Patient B:
      
      i. On or around 12 July 2013;
      
      ii. On or around 30 June 2015.

   b. In relation to Patient C:
      
      i. On or around 12 June 2013;
      
      ii. On or around 16 June 2015.

   c. In relation to Patient D:
      
      i. On or around 3 January 2014;
      
      ii. On or around 12 March 2015;
      
      iii. On or around 23 March 2016.

   d. In relation to Patient E:
      
      i. On or around 23 April 2013;
      
      ii. On or around 4 September 2015.

   e. In relation to Patient F:
      
      i. On or around 7 May 2013;
      
      ii. On or around 6 May 2014;
      
      iii. On or around 8 May 2015;
      
      iv. On a date unknown in May 2016.

7. You failed to make any, or any adequate record of any enquiry of the current visual status:

   a. In relation to Patient B:
      
      i. On or around 12 July 2013;
      
      ii. On or around 30 June 2015.

   b. In relation to Patient C:
      
      i. On or around 12 June 2013;
      
      ii. On or around 16 June 2015.
c. In relation to Patient D:
   i. On or around 3 January 2014;
   ii. On or around 12 March 2015;
   iii. On or around 23 March 2016.

d. In relation to Patient E:
   i. On or around 23 April 2013;
   ii. On or around 4 September 2015.

e. In relation to Patient F:
   i. On or around 7 May 2013;
   ii. On or around 6 May 2014;
   iii. On or around 8 May 2015;
   iv. On a date unknown in May 2016.

8. You failed to make any or any adequate enquiry into the presenting symptoms:
   a. In relation to Patient G on or around 14 August 2015;
   b. In relation to Patient H on or around 27 October 2015;

9. You failed to make any or any adequate record of any enquiry into the presenting symptoms and/or reason for visit:
   a. In relation to Patient G on or around 14 August 2015;
   b. In relation to Patient H on or around 27 October 2015.

10. You failed to make any or any adequate enquiries as to patients' visual requirements in relation to their work and/or activities and/or driving:
   a. In relation to Patient H on or around 27 October 2015
   b. In relation to Patient B:
      i. On or around 12 July 2013;
      ii. On or around 30 June 2015.
   c. In relation to Patient C:
      i. On or around 12 June 2013;
      ii. On or around 16 June 2015.
   d. In relation to Patient D:
      i. On or around 3 January 2014;
      ii. On or around 12 March 2015;
iii. On or around 23 March 2016.

e. In relation to Patient E:
   i. On or around 23 April 2013;
   ii. On or around 4 September 2015.

f. In relation to Patient F:
   i. On or around 7 May 2013;
   ii. On or around 6 May 2014;
   iii. On or around 8 May 2015;
   iv. On a date unknown in May 2016.

g. In relation to Patient I:
   i. On or around 24 October 2013;
   ii. On or around 11 March 2014;
   iii. On or around 21 August 2014;
   iv. On or around 16 March 2015;
   v. On or around 13 August 2015;
   vi. On or around 11 February 2016;
   vii. On or around 10 March 2016.

11. You failed to make any or any adequate record of any enquiries as to patients' visual requirements in relation to their work and/or activities and/or driving:

   a. In relation to Patient H on or around 27 October 2015
   b. In relation to Patient B:
      i. On or around 12 July 2013;
      ii. On or around 30 June 2015.

   c. In relation to Patient C:
      i. On or around 12 June 2013;
      ii. On or around 16 June 2015.

   d. In relation to Patient D:
      i. On or around 3 January 2014;
      ii. On or around 12 March 2015;
      iii. On or around 23 March 2016.

   e. In relation to Patient E:
      i. On or around 23 April 2013;
      ii. On or around 4 September 2015.
f. In relation to Patient F:
   
i. On or around 7 May 2013;
ii. On or around 6 May 2014;
iii. On or around 8 May 2015;
iv. On a date unknown in May 2016.

g. In relation to Patient I:
   
i. On or around 24 October 2013;
ii. On or around 11 March 2014;
iii. On or around 21 August 2014;
iv. On or around 16 March 2015;
v. On or around 13 August 2015;
vi. On or around 11 February 2016;
vii. On or around 10 March 2016.

12. You failed to make any or any adequate enquiry into patients’ general health and/or medication:

   a. In relation to Patient G on or around 14 August 2015;
b. In relation to Patient J:
   
i. On or around 5 August 2013;
ii. On or around 3 February 2015.

c. In relation to Patient K on or around 8 September 2015;
d. In relation to Patient B:
   
i. On or around 12 July 2013;
ii. On or around 30 June 2015.

e. In relation to Patient C:
   
i. On or around 12 June 2013;
ii. On or around 16 June 2015.

f. In relation to Patient D:
   
i. On or around 3 January 2014;
ii. On or around 12 March 2015;
iii. On or around 23 March 2016.

g. In relation to Patient E:
   
i. On or around 23 April 2013;
ii. On or around 4 September 2015.
h. In relation to Patient F:
   i. On or around 7 May 2013;
   ii. On or around 6 May 2014;
   iii. On or around 8 May 2015;
   iv. On a date unknown in May 2016.

i. In relation to Patient I:
   i. On or around 24 October 2013;
   ii. On or around 11 March 2014;
   iii. On or around 21 August 2014;
   iv. On or around 16 March 2015;
   v. On or around 13 August 2015;
   vi. On or around 11 February 2016;
   vii. On or around 10 March 2016.

13. You failed to make any or any adequate record of any enquiry into patients’ general health and or medication:

   a. In relation to Patient G on or around 14 August 2015;
   b. In relation to Patient J:
      i. On or around 5 August 2013;
      ii. On or around 3 February 2015.
   c. In relation to Patient K on or around 8 September 2015;
   d. In relation to Patient B:
      i. On or around 12 July 2013;
      ii. On or around 30 June 2015.
   e. In relation to Patient C:
      i. On or around 12 June 2013;
      ii. On or around 16 June 2015.
   f. In relation to Patient D:
      i. On or around 3 January 2014;
      ii. On or around 12 March 2015;
      iii. On or around 23 March 2016.
   g. In relation to Patient E:
      i. On or around 23 April 2013;
      ii. On or around 4 September 2015.
h. In relation to Patient F:
   i. On or around 7 May 2013;
   ii. On or around 6 May 2014;
   iii. On or around 8 May 2015;
   iv. On a date unknown in May 2016.

i. In relation to Patient I:
   i. On or around 24 October 2013;
   ii. On or around 11 March 2014;
   iii. On or around 21 August 2014;
   iv. On or around 16 March 2015;
   v. On or around 13 August 2015;
   vi. On or around 11 February 2016;
   vii. On or around 10 March 2016.

14. You failed to make any or any adequate enquiry into patients' ocular and/or family ocular history:

   a. In relation to Patient G on or around 14 August 2015;
   b. In relation to Patient J:
      i. On or around 5 August 2013;
      ii. On or around 3 February 2015.
   c. In relation to Patient K on or around 8 September 2015;
   d. In relation to Patient H on or around 27 October 2015;
   e. In relation to Patient B:
      i. On or around 12 July 2013;
      ii. On or around 30 June 2015.
   f. In relation to Patient C:
      i. On or around 12 June 2013;
      ii. On or around 16 June 2015.
   g. In relation to Patient D:
      i. On or around 3 January 2014;
      ii. On or around 12 March 2015;
      iii. On or around 23 March 2016.
   h. In relation to Patient E:
      i. On or around 23 April 2013;
      ii. On or around 4 September 2015.
i. In relation to Patient F:
   i. On or around 7 May 2013;
   ii. On or around 6 May 2014;
   iii. On or around 8 May 2015;
   iv. On a date unknown in May 2016.

j. In relation to Patient I:
   i. On or around 24 October 2013;
   ii. On or around 11 March 2014;
   iii. On or around 21 August 2014;
   iv. On or around 16 March 2015;
   v. On or around 13 August 2015;
   vi. On or around 11 February 2016;
   vii. On or around 10 March 2016.

15. You failed to make any or any adequate record of any enquiry into patients’ ocular and/or family ocular history:

   a. In relation to Patient G on or around 14 August 2015;
   b. In relation to Patient J:
      i. On or around 5 August 2013;
      ii. On or around 3 February 2015.
   c. In relation to Patient K on or around 8 September 2015;
   d. In relation to Patient H on or around 27 October 2015;
   e. In relation to Patient B:
      i. On or around 12 July 2013;
      ii. On or around 30 June 2015.
   f. In relation to Patient C:
      i. On or around 12 June 2013;
      ii. On or around 16 June 2015.
   g. In relation to Patient D:
      i. On or around 3 January 2014;
      ii. On or around 12 March 2015;
      iii. On or around 23 March 2016.
   h. In relation to Patient E:
      i. On or around 23 April 2013;
ii. On or around 4 September 2015.

i. In relation to Patient F:

   i. On or around 7 May 2013;
   ii. On or around 6 May 2014;
   iii. On or around 8 May 2015;
   iv. On a date unknown in May 2016.

j. In relation to Patient I:

   i. On or around 24 October 2013;
   ii. On or around 11 March 2014;
   iii. On or around 21 August 2014;
   iv. On or around 16 March 2015;
   v. On or around 13 August 2015;
   vi. On or around 11 February 2016;
   vii. On or around 10 March 2016.

16. You failed to carry out any assessment of basic binocular vision:

   a. In relation to Patient J:

      i. On or around 5 August 2013;
      ii. On or around 3 February 2015.

   b. In relation to Patient F:

      i. On or around 7 May 2013;
      ii. On or around 6 May 2014;
      iii. On or around 8 May 2015;
      iv. A date unknown in May 2016.

17. You failed to make any or any adequate record of any assessment of basic binocular vision:

   a. In relation to Patient J:

      i. On or around 5 August 2013;
      ii. On or around 3 February 2015.

   b. In relation to Patient F:

      i. On or around 7 May 2013;
      ii. On or around 6 May 2014;
      iii. On or around 8 May 2015;
      iv. A date unknown in May 2016.
18. You failed to make an adequate record of the findings of the internal and/or external eye examinations:

a. In relation to Patient G on or around 14 August 2015;

b. In relation to Patient J:
   i. On or around 5 August 2013;
   ii. On or around 3 February 2015.

c. In relation to Patient K on or around 8 September 2015;

d. In relation to Patient H on or around 27 October 2015;

e. In relation to Patient B:
   i. On or around 12 July 2013;
   ii. On or around 30 June 2015.

f. In relation to Patient C:
   i. On or around 12 June 2013;
   ii. On or around 16 June 2015.

g. In relation to Patient D:
   i. On or around 3 January 2014;
   ii. On or around 12 March 2015;
   iii. On or around 23 March 2016.

h. In relation to Patient E:
   i. On or around 23 April 2013;
   ii. On or around 4 September 2015.

i. In relation to Patient F:
   i. On or around 7 May 2013;
   ii. On or around 6 May 2014;
   iii. On or around 8 May 2015;
   iv. On a date unknown in May 2016.

j. In relation to Patient I:
   i. On or around 24 October 2013;
   ii. On or around 11 March 2014;
   iii. On or around 21 August 2014;
   iv. On or around 16 March 2015;
   v. On or around 13 August 2015;
   vi. On or around 11 February 2016;
   vii. On or around 10 March 2016.
19. You failed to carry out visual fields tests when it was indicated to do so:

   a. On or around 11 March 2014 in relation to Patient I;
   b. On a date unknown in May 2016 in relation to Patient F.

20. You failed to make any or any adequate record of visual fields tests carried out:

   a. On a date unknown in May 2016 in relation to Patient F;
   b. On or around 27 October 2015 in relation to Patient H;
   c. On or around 30 June 2015 in relation to Patient B;
   d. On or around 23 March 2016 in relation to Patient D;
   e. On or around 4 September 2015 in relation to Patient E;
   f. In relation to Patient I:

      i. On or around 11 March 2014;
      ii. On or around 13 August 2015;
      iii. On or around 11 February 2016;
      iv. On or around 10 March 2016.

21. You failed to undertake tonometry testing:

   a. On or around 12 July 2013 in relation to Patient B;
   b. On or around 23 April 2013 in relation to Patient E;
   c. In relation to Patient D:

      i. On or around 3 January 2014;
      ii. On or around 12 March 2015.

   d. In relation to Patient C:

      i. On or around 12 June 2013;
      ii. On or around 16 June 2015.

   e. In relation to Patient I:

      i. On or around 24 October 2013;
      ii. On or around 11 March 2014;
      iii. On or around 21 August 2014;
      iv. On or around 16 March 2015.

22. You failed to make any record of tonometry testing:

   a. On or around 12 July 2013 in relation to Patient B;
   b. On or around 23 April 2013 in relation to Patient E;
   c. In relation to Patient D:

      i. On or around 3 January 2014;
ii. On or around 12 March 2015.

d. In relation to Patient C:

   i. On or around 12 June 2013;
   ii. On or around 16 June 2015.

e. In relation to Patient I:

   i. On or around 24 October 2013;
   ii. On or around 11 March 2014;
   iii. On or around 21 August 2014;
   iv. On or around 16 March 2015.

23. On a date unknown between 25 June 2015 and 4 November 2015 you added to the record of Patient L's examination of 24 March 2015 intraocular pressure scores.

24. You failed to maintain an adequate standard of record keeping:

   a. Patient A on or around 18 March 2016;
   b. Patient G on or around 14 August 2015;
   c. Patient J between around 5 August 2013 and around 3 February 2015;
   d. Patient K on around 8 September 2015;
   e. Patient H on or around 27 October 2015;
   f. Patient B between around 12 July 2013 and around 30 June 2015;
   g. Patient C between around 12 June 2013 and around 16 June 2015;
   h. Patient D between around 3 January 2014 and around 23 March 2016;
   i. Patient E between around 23 April 2013 and around 4 September 2015;
   j. Patient F between around 7 May 2013 and around 31 May 2016;

As a result of the matters set out above your fitness to practise is impaired by reason of your misconduct and/or deficient professional performance.

DETERMINATION

Admissions in relation to the particulars of the allegation

The Registrant did not formally make any admissions.

Background to the allegation

The Registrant is currently registered as an optometrist. At the time of these events, he had two practices in Redacted, one in Redacted and one in Redacted. This matter was first brought to the attention of the General Optical Council (‘the Council’) by way of a referral from NHS England Redacted (“NHSE”).
The Registrant was providing services to NHSE, holding a contract to carry out General Ophthalmic Services (“GOS”) with the NHS. In its management of the GOS contract routine inspections are undertaken by NHSE to ensure compliance with the standards required of the contract. On 25 June 2015, a Contract Manager and Clinical Adviser, Redacted (“Ms A”), attended the Redacted practice in order to carry out a routine assurance inspection. At this visit a number of concerns into the Registrant’s practice were noted. Ms A duly reported matters to NHSE and a formal investigation was opened.

As part of the investigation a number of further visits to the Registrant’s practices took place during which selections of his patient records were reviewed. Visits took place at both the Redacted and Redacted practices on 25 September 2015, at the Redacted Practice on 15 October 2015, and the Redacted Practice on 3 November 2015. In addition, as part of the process, meetings were held with the Registrant on 5 October 2015 and 11 February 2016, at which notes were taken.

Ms A reported her finding to NHSE’s Performance Advisory Group on 1 March 2016. In addition to imposing conditions upon the Registrant’s inclusion on the Ophthalmic Performance List, it was decided that Ms A would visit the Registrant’s practice and observe the Registrant undertake an eye examination of the patient.

As a result of Ms A’s being reported findings to NHSE, this matter was referred to the Council.

Findings in relation to the facts

The Committee heard from two witnesses on behalf of the Council. These were:

i) Redacted, a Contract Manager and Clinical Adviser, who carried out an observation and investigation in relation to the Registrant’s practice;

ii) Dr Robert Harper, Optometrist Consultant at the Manchester Royal Eye Hospital who provided an Expert Witness Report on behalf of the Council.

Ms A adopted her statement made on 13 September 2018. She explained that as a Clinical Adviser, her services were engaged on the basis of assessment and investigation. This was done on a part time basis and she had carried out such assessments and observations for the last 10 years. She was also a qualified optometrist of 20 years’ experience.

Ms A presented as a competent and composed witness, who corrected an earlier error that she had made in her statement, where she had used the number “18” rather than “17” in a transcribing error. She answered all the questions that were put to her in a straightforward manner and gave comprehensive and uncontroversial evidence. She observed the Registrant with a patient and carried out two meetings with the Registrant in which she made contemporaneous notes, which she transcribed in producing a statement. The Committee found her to be a reliable witness.

Dr Robert Harper, adopted his Expert Witness Report on behalf of the Council, dated 30 July 2018 as his evidence. He appeared to be an experienced professional who was careful to qualify his opinion, when he moved into areas of speculation or where others might take a different professional view. He entertained, if not adopted, alternative scenarios and the Committee found him to be reliable.
Particular 1 a, b and c

1. On 18 March 2016 you failed to obtain an adequate history of Patient A in that you did not obtain any or any adequate information as to:
   a. general health and/or
   b. medical history and/or
   c. family history.

Found proved.

At paragraph 20 of her witness statement at page 18 of the bundle Ms A sets out that:

"Before I attended the Practice the Registrant had already checked the date of Patient A’s last sight test as Patient A had visited the Practice previously. The Registrant asked Patient A questions around ocular history as Patient MC’s [sic] left eye had been injured a few years ago resulting in scarring and reduced visual acuity. The Registrant did not obtain any other history including general health, medical and family history."

Dr Robert Harper, opines at paragraph 5.1.3 of his report at page 47 of the bundle that:

“Although the Registrant had examined MC [sic] previously, a patient’s individual circumstances in all of these respects can (and do often) change between visits to an optometrist. In my opinion, omission of questioning on a patient’s general health, medications and family history falls below the standard expected of a reasonably competent optometrist; to regularly omit to do so would fall far below the standard expected of a reasonably competent optometrist."

The Committee found that some ocular history of Patient A was taken by the Registrant but this did not extend to recording details of general health, medical and family history. The Committee noted that Ms A was present during Patient A’s consultation with the Registrant and that they had her direct evidence of her observations.

Particular 2 a and b

On 18 March 2016 you failed to carry out an adequate examination of Patient A’s fundus in that:
   a. You carried out a direct ophthalmoscopy looking only straight ahead and/or at a working distance of approximately 10cm;
   b. You carried out an indirect ophthalmoscopy with an angle-poise light.

Found proved.

Ms A describes both the direct and indirect ophthalmoscopies which were performed by the Registrant in respect of Patient A. In relation to the direct ophthalmoscopy Ms A states at paragraph 24 at page 18 of the Council’s bundle that: “Direct ophthalmoscopy was undertaken by the Registrant in the primary position at a working distance of approximately 10cm.”

Dr Harper sets out his opinion of this at paragraph 5.1.5 at page 47 of the Council’s bundle:
“Ms [A] describes the Registrant as using the direct ophthalmoscope ‘in the primary position’ (i.e. straight ahead) only and at a ‘working distance of approximately 10cm’. In my opinion, if what she writes is accurate, Ms [A] is quite correct to highlight the deficiency in the Registrant’s technique, since at this working distance (and without asking the patient to move their eye in different directions of gaze) only a very limited field of visualisation of the retina at back of the eye would have been feasible.”

He did point out that the requirements of a sight test would not require both a direct and indirect ophthalmoscopy to be carried out. However, the evidence from Ms A is that neither test was carried out adequately.

Ms A describes the indirect ophthalmoscopy which was carried out with a VOLK lens at paragraph 25 at page 19 of the bundle where she sets out that:

“The VOLK lens was situated on the consulting room desk when I arrived at the Practice. It had 2 post-it type notes; one stating “2 inches from patient eye” and the other one stating “silver edge towards patient”. The VOLK lens is a 20D lens usually used with a head band Binocular Indirect Ophthalmoscope (“BIO”). Usually a 90D or equivalent is used for slit lamp BIO. However, the Registrant proceeded to use an angle-poise lamp positioned on the wall behind Patient MC and the VOLK lens held in front of Patient MC’s eye to undertake the examination. Upon completion of both eyes the Registrant asked "have I done VOLK now"; I replied "is that what you would usually do?” and the Registrant replied “yes”.

The Committee found that while both a direct and indirect examination of Patient A was attempted by the Registrant under the observation of Ms A, both examinations were inadequate. Dr Harper confirmed that the direct test would require a variation in gaze and that an angle-poise lamp is not suitable for an adequate indirect ophthalmoscopy to be carried out.

**Particular 3:**

On 18 March 2016 you failed to carry out an adequate assessment of Patient A’s visual fields in that:

a. You were unable, adequately or at all, to operate the testing equipment;

b. You carried out the test without dimming the lighting in the room;

c. You did not test Patient A’s left eye.

**Found proved.**

Ms A watched the Registrant perform a visual fields assessment of Patient A. She describes what she saw:

“The Registrant positioned Patient MC [sic] to take the visual fields assessment and stated “Anthony has set this up for me” and asking Patient MC [sic] “you are over 50 aren’t you?”. The Registrant then remembered that the test is done monocularly and asked Patient MC to put the eye patch over his left eye. The Registrant tried several buttons before the test resumed; once it started the Registrant proceeded to ask me questions like "do you normally let it go all the way or stop it after 50 or 60 points?”
I asked the Registrant what test he was using and he could not tell me. The Registrant then said "I do not remember ever taking it to the end". I then asked to see the monitor and advised him that it was in demo mode, which is used to show patients how the test works. There were instructions on the screen stating this. The Registrant replied "oh am I?" and had several attempts at starting the test properly. It continued in demo mode and I advised the Registrant again at which point he managed to get the test to start.

After a few minutes the Registrant stopped the test stating "you've got one error out of 200, I think that's OK. How many questions will it ask I wonder?" the test was then exited with no record being made of the results. Only the right eye was attempted, room illumination was on throughout, which it should be dimmed.

Dr Harper stated that if Ms A’s description is accurate it is clear that the Registrant lacks the skill to undertake a visual fields test. However, he goes on to say that often visual field testing is delegated and so some unfamiliarity with the equipment might be excusable but that:

"regardless of the local arrangements for day to day testing of visual fields, it would be expected that a reasonably competent optometrist would know about the basic operation of the visual field equipment, the importance of dimming room illumination to undertake the test, and the importance of undertaking the test in each eye, and not just the right eye"

Dr Harper also notes that in Patient A’s records the visual fields test has been documented simply by two ticks. Dr Harper opines that a reasonably competent optometrist would be expected to make a note of the visual field test result. He concludes that:

"In my opinion, and on the basis that Ms A’s descriptions are accepted as accurate, the Registrant has displayed a fairly basic lack of awareness of how to undertake and how to record the results of visual field testing in his examination of Patient MC [sic], and as such, his lack of competence herein falls far below the standard expected of a reasonably competent optometrist."

Particular 4:

On 18 March 2016 you did not make an adequate record of your appointment with Patient A in that:

a. You failed to record, adequately or at all, Patient A’s presenting symptoms and/or reason for attending for examination;
b. You failed to adequately record the results of the visual fields test;
c. You failed to record the time of day intra ocular pressure was measured;
d. You incorrectly recorded intra ocular pressure in Patient A’s right eye as 17;
e. You failed to record adequate detail of the internal and/or external eye examination;
f. You failed to record, adequately or at all, any advice given;
You failed to record, adequately or at all, any conclusions reached from the examination.

4a-e found proved; f and g not proved.

The record card from this appointment had been considered by Dr Harper. He describes the record keeping as 'very cursory' and says that it 'omits key information' in particular:

- The presenting symptoms or reason for the examination;
- The results of the visual fields test (in that just a dash was recorded);
- The time of day the intraocular pressure was recorded;
- Adequate detail of the internal/external eye examinations;
- The conclusion reached by the examination.

The Committee has relied upon Dr Harper's expert evidence, albeit it notes that it is not established that there was a requirement to record the time of day that the intraocular pressure was recorded. Further, the Committee has accepted the evidence of Ms A who said that the dial showed “10” even though the recorded figure by the Registrant was “17”. (She corrected her earlier mistake in noting this as 18, given that his record has indicated 17; neither figure is correct, as the dial showed “10”.)

Particular 4f) and 4g) were not found proved because the Committee concluded that there was insufficient evidence to persuade it that advice had been given or conclusions reached, which were capable of being recorded.

**Particular 5:**

On 18 March 2016 you made an inaccurate record of your appointment with Patient A in that:

a. You recorded a dash to indicate that a visual fields test had been carried out on Patient A's left eye when it had not;

b. You recorded intraocular eye pressure as 17 for both of Patient A's eyes when you had only measured the right eye;

**Found proved.**

Dr Harper raises concerns that visual fields tests had been conducted on only the right eye but that there was a dash in the records indicating that the test had been undertaken in relation to the left eye when it had not.

In a similar vein the Registrant recorded that the intraocular pressure in the left eye had been measured when Ms A reports that this was not so. Therefore, the record created for this patient was not accurate and presented a misleading picture of the eye examination he had conducted.

**Particular 6:**

You failed to make any, or any adequate enquiry of the current visual status:
a. In relation to Patient B:
   i. On or around 12 July 2013;
   ii. On or around 30 June 2015.

b. In relation to Patient C:
   i. On or around 12 June 2013;
   ii. On or around 16 June 2015.

c. In relation to Patient D:
   i. On or around 3 January 2014;
   ii. On or around 12 March 2015;
   iii. On or around 23 March 2016.

d. In relation to Patient E:
   i. On or around 23 April 2013;
   ii. On or around 4 September 2015.

e. In relation to Patient F:
   i. On or around 7 May 2013;
   ii. On or around 6 May 2014;
   iii. On or around 8 May 2015;
   iv. On a date unknown in May 2016.

Not found proved.

In determining this particular of the Allegation, the Committee relied upon the notes written by the Registrant on site, and the Report created by Dr Harper. The Committee was not satisfied that the interpretation of the Registrant’s sight test records was sufficient to prove the extent of the enquiry that had taken place. Dr Harper conceded that enquiries may have been made without the detail of these enquiries or the responses to them being recorded. A, ‘he would ask the questions, (about medical history), but would only record areas of concern.’ Given the burden and standard of proof, the Committee was not satisfied that the Council has proved these matters, especially in light of some notations which do indicate that enquiry of some form had been made.

Particular 7

7. You failed to make any, or any adequate record of any enquiry of the current visual status:

a. In relation to Patient B:
   i. On or around 12 July 2013;
   ii. On or around 30 June 2015.

b. In relation to Patient C:
   i. On or around 12 June 2013;
   ii. On or around 16 June 2015.

c. In relation to Patient D:
   i. On or around 3 January 2014;
   ii. On or around 12 March 2015;
   iii. On or around 23 March 2016.

d. In relation to Patient E:
   i. On or around 23 April 2013;
   ii. On or around 4 September 2015.

e. In relation to Patient F:
   i. On or around 7 May 2013;
ii. On or around 6 May 2014;
iii. On or around 8 May 2015;
iv. On a date unknown in May 2016.

**Found proved.**

Insofar as this charge is concerned, the Committee did accept Dr Harper's assessment that:

"Patients’ symptoms and/or the reason for their visits is often not documented and/or in those cases where there is some such note made, there is a lack of clarity and follow-up questioning on the presenting complaint. There is [no enquiry made of the current visual status of the patient] and/or no record of any enquiries made therein in the following cases: Patient B; Patient C, Patient D, Patient E and Patient F."

**Patient B**

There is a record of “broken frame?” being made in the patient's notes by the Registrant on 12 July 2013. However, on neither 12 July 2013 or 30 June 2015 was any adequate record of any enquiry of the patient’s current visual status made.

The Registrant did record the patient’s eye test results but not any enquiry made about their visual status.

**Patient D**

The Registrant did indicate in the patient notes on 3 January 2014, “R>L” which has been interpreted by Dr Harper as meaning that the vision is greater in the right eye than the left, but no further detail than this. Dr Harper indicated that there was no clear documentation about any concerns resulting from this in the patient notes for 12 March 2015 or 23 March 2016. The Committee relied on Dr Harper's interpretation as an expert witness.

**Patient E**

Dr Harper considered the patient notes and indicated that the current visual status had not been recorded for the patient on 23 April 2013 or 4 September 2015.

**Patient F**

Dr Harper evaluated the patient notes created by the Registrant for this patient between 2013 and 2016. The Committee accepted what Dr Harper had to say about the patient notes for Patient F: “There is no clear documentation of any enquiry as to what, if any, concerns there were about patients’ actual vision. Patient’s diabetic status is noted and some comments about his diabetic eye status are noted but not how Patient F is actually seeing at the time of the appointments.”

**Particular 8:**

**You failed to make any or any adequate enquiry into the presenting symptoms:**

a. In relation to Patient G on or around 14 August 2015.

**Not found proved.**
The Committee took the approach adopted above that there was nobody to observe the interaction of the Registrant with Patient G. Given the burden and standard of proof, the Committee is not able to find that this charge is made out. There is no direct evidence as to what actually occurred during the appointment for Patient G on or around 14 August 2015.

**Particular 9:**

You failed to make any or any adequate record of any enquiry into the presenting symptoms and/or reason for visit:
   a. In relation to Patient G on or around 14 August 2015;
   b. In relation to Patient H on or around 27 October 2015.

Found proved.

The Committee was assisted by Dr Harper's consideration of the patient notes. While Dr Harper acknowledges that there is a question over the legibility of the Registrant’s handwriting, there is no sufficient record of either presenting symptoms or the reasons for the visit being recorded by the Registrant on either of these occasions. Even if the illegible handwriting does allude to this, the Committee was of the view that this content would not be an adequate record as it would be of little use to another optometrist if it could not be read.

**Particular 10:**

You failed to make any or any adequate enquiries as to patients' visual requirements in relation to their work and/or activities and/or driving:
   a. In relation to Patient H on or around 27 October 2015
   b. In relation to Patient B:
      i. On or around 12 July 2013;
      ii. On or around 30 June 2015.
   c. In relation to Patient C:
      i. On or around 12 June 2013;
      ii. On or around 16 June 2015.
   d. In relation to Patient D:
      i. On or around 3 January 2014;
      ii. On or around 12 March 2015;
      iii. On or around 23 March 2016.
   e. In relation to Patient E:
      i. On or around 23 April 2013;
      ii. On or around 4 September 2015.
   f. In relation to Patient F:
      i. On or around 7 May 2013;
      ii. On or around 6 May 2014;
      iii. On or around 8 May 2015;
      iv. On a date unknown in May 2016.
   g. In relation to Patient I:
      i. On or around 24 October 2013;
      ii. On or around 11 March 2014;
      iii. On or around 21 August 2014;
iv. On or around 16 March 2015;
v. On or around 13 August 2015;
vi. On or around 11 February 2016;
vii. On or around 10 March 2016.

Not found proved.

Given the standard and burden of proof that applies, the Committee was not able to find this charge proved. There was insufficient evidence that adequate enquires had not been made. The Committee was mindful that they were relying on the secondary interpretation of a secondary document, in circumstances where Dr Harper himself acknowledged that patient cards completed in manuscript, as is not uncommon in community settings, present an imperfect record of what occurred at an appointment.

The Committee also noted Ms A’s evidence that the Registrant’s practice is only to record what he considers to be relevant.

**Particular 11:**

You failed to make any or any adequate record of any enquiries as to patients’ visual requirements in relation to their work and/or activities and/or driving:

a. In relation to Patient H on or around 27 October 2015
b. In relation to Patient B:
   i. On or around 12 July 2013;
   ii. On or around 30 June 2015.
c. In relation to Patient C:
   i. On or around 12 June 2013;
   ii. On or around 16 June 2015.
d. In relation to Patient D:
   i. On or around 3 January 2014;
   ii. On or around 12 March 2015;
   iii. On or around 23 March 2016.
e. In relation to Patient E:
   i. On or around 23 April 2013;
   ii. On or around 4 September 2015.
f. In relation to Patient F:
   i. On or around 7 May 2013;
   ii. On or around 6 May 2014;
   iii. On or around 8 May 2015;
   iv. On a date unknown in May 2016.
g. In relation to Patient I:
   i. On or around 24 October 2013;
   ii. On or around 11 March 2014;
   iii. On or around 21 August 2014;
   iv. On or around 16 March 2015;
v. On or around 13 August 2015;
vi. On or around 11 February 2016;
vii. On or around 10 March 2016.
Found proved.

The Committee accepted Dr Harper’s evidence as set out in his report:

“There is no record as to whether the Registrant asked about whether his adult patients were working, i.e. in specific occupations with particular visual requirements, or were retired with hobbies/activities, and/or whether they drive. This general failure to ask (and/or to record responses where asked) over the numerous examinations of the 7 adult patients reviewed in this sample is a failing that falls below the standard expected of a reasonably competent optometrist.”

There is no entry relating to ‘work and/or activities and/or driving’ recorded for these patients on these dates in Dr Harper’s analysis. These cover 7 patients across more than 20 appointments. The Committee therefore finds this particular proved.

Particular 12:

12. You failed to make any or any adequate enquiry into patients' general health and/or medication:
   a. In relation to Patient G on or around 14 August 2015;
   b. In relation to Patient J:
      i. On or around 5 August 2013;
      ii. On or around 3 February 2015.
   c. In relation to Patient K on or around 8 September 2015;
   d. In relation to Patient B:
      i. On or around 12 July 2013;
      ii. On or around 30 June 2015.
   e. In relation to Patient C:
      i. On or around 12 June 2013;
      ii. On or around 16 June 2015.
   f. In relation to Patient D:
      i. On or around 3 January 2014;
      ii. On or around 12 March 2015;
      iii. On or around 23 March 2016.
   g. In relation to Patient E:
      i. On or around 23 April 2013;
      ii. On or around 4 September 2015.
   h. In relation to Patient F:
      i. On or around 7 May 2013;
      ii. On or around 6 May 2014;
      iii. On or around 8 May 2015;
      iv. On a date unknown in May 2016.
   i. In relation to Patient I:
      i. On or around 24 October 2013;
      ii. On or around 11 March 2014;
      iii. On or around 21 August 2014;
      iv. On or around 16 March 2015;
      v. On or around 13 August 2015;
      vi. On or around 11 February 2016;
vii. On or around 10 March 2016.

Not found proved.
The Committee applied a consistent approach as outlined above distinguishing the act of making enquiries from the act of making adequate records. Given the burden and standard of proof and the lack of direct evidence as to how or whether the Registrant conducted his enquiries, the Committee was not prepared to make the inference that a lack of recording equated with an absence of adequate enquiry.

Particular 13
You failed to make any or any adequate record of any enquiry into patients' general health and or medication:

a. In relation to Patient G on or around 14 August 2015;

b. In relation to Patient J:
   i. On or around 5 August 2013;
   ii. On or around 3 February 2015.

c. In relation to Patient K on or around 8 September 2015;

d. In relation to Patient B:
   i. On or around 12 July 2013;
   ii. On or around 30 June 2015.

e. In relation to Patient C:
   i. On or around 12 June 2013;
   ii. On or around 16 June 2015.

f. In relation to Patient D:
   i. On or around 3 January 2014;
   ii. On or around 12 March 2015;
   iii. On or around 23 March 2016.

g. In relation to Patient E:
   i. On or around 23 April 2013;
   ii. On or around 4 September 2015.

h. In relation to Patient F:
   i. On or around 7 May 2013;
   ii. On or around 6 May 2014;
   iii. On or around 8 May 2015;
   iv. On a date unknown in May 2016.

i. In relation to Patient I:
i. On or around 24 October 2013;
ii. On or around 11 March 2014;
iii. On or around 21 August 2014;
iv. On or around 16 March 2015;
v. On or around 13 August 2015;
vi. On or around 11 February 2016;
vii. On or around 10 March 2016.

Found proved.

The Committee was assisted by Dr Harper who indicated in his report:

“Patients’ general health is typically not described at all (and where some mention is made, such as in those patients with diabetes, there is insufficient follow up on diabetic duration, control, and attendances at retinal screening for example). Related to this deficiency in asking about and/or recording the asking about patients’ general health, there is also an absence of asking about and/or recording the asking about information on patients’ medications.”

There was little evidence of the adequate recording of relevant information into the general health and/or medication of patients. Where there was information this was scant and in Dr Harper’s view insufficient. The Committee accepted the opinion of Dr Harper.

Particular 14:

You failed to make any or any adequate enquiry into patients' ocular and/or family ocular history:

a. In relation to Patient G on or around 14 August 2015;
b. In relation to Patient J:
   i. On or around 5 August 2013;
   ii. On or around 3 February 2015.
c. In relation to Patient K on or around 8 September 2015;
d. In relation to Patient H on or around 27 October 2015;
e. In relation to Patient B:
   i. On or around 12 July 2013;
   ii. On or around 30 June 2015.
f. In relation to Patient C:
   i. On or around 12 June 2013;
   ii. On or around 16 June 2015.
g. In relation to Patient D:
   i. On or around 3 January 2014;
   ii. On or around 12 March 2015;
   iii. On or around 23 March 2016.
h. In relation to Patient E:
   i. On or around 23 April 2013;
   ii. On or around 4 September 2015.

i. In relation to Patient F:
   i. On or around 7 May 2013;
   ii. On or around 6 May 2014;
   iii. On or around 8 May 2015;
   iv. On a date unknown in May 2016.

j. In relation to Patient I:
   i. On or around 24 October 2013;
   ii. On or around 11 March 2014;
   iii. On or around 21 August 2014;
   iv. On or around 16 March 2015;
   v. On or around 13 August 2015;
   vi. On or around 11 February 2016;
   vii. On or around 10 March 2016.

Not found proved.

The Committee has maintained its consistent approach as outlined above in distinguishing the making of an adequate enquiry with the making of an adequate record. Given the burden and standard of proof, the Committee is not satisfied that there is evidence that allows it to find this particular proved.

Particular 15:

You failed to make any or any adequate record of any enquiry into patients' ocular and/or family ocular history:

a. In relation to Patient G on or around 14 August 2015;

b. In relation to Patient J:
   i. On or around 5 August 2013;
   ii. On or around 3 February 2015.

c. In relation to Patient K on or around 8 September 2015;

d. In relation to Patient H on or around 27 October 2015;

e. In relation to Patient B:
   i. On or around 12 July 2013;
   ii. On or around 30 June 2015.

f. In relation to Patient C:
   i. On or around 12 June 2013;
ii. On or around 16 June 2015.

g. In relation to Patient D:
i. On or around 3 January 2014;
ii. On or around 12 March 2015;
iii. On or around 23 March 2016.
h. In relation to Patient E:
i. On or around 23 April 2013;
ii. On or around 4 September 2015.
i. In relation to Patient F:
i. On or around 7 May 2013;
ii. On or around 6 May 2014;
iii. On or around 8 May 2015;
iv. On a date unknown in May 2016.
j. In relation to Patient I:
i. On or around 24 October 2013;
ii. On or around 11 March 2014;
iii. On or around 21 August 2014;
iv. On or around 16 March 2015;
v. On or around 13 August 2015;
vi. On or around 11 February 2016;
vii. On or around 10 March 2016.

Found proved.

The Committee was assisted by Dr Harper’s report which contained the following:

“Patients’ family ocular histories (e.g. the presence or absence of a first degree relative with glaucoma) are not documented and patients’ own previous ocular histories are given only very limited attention. These omissions and/or recording failings are prevalent across all of the cases reviewed and result in the Registrant not fully being able to assess his patients’ risks of ocular disorders/disease and the tests which may be required as part of their examination.”

The Committee did consider whether there was simply an absence of relevant information and whether this could explain why no information was recorded about these patients’ families. However, the Committee was of the view and accepted Dr Harper’s evidence that even the absence of first-degree relatives with glaucoma or other significant ocular history was a relevant matter and necessary to record.
Particular 16:
You failed to carry out any assessment of basic binocular vision:

a. In relation to Patient J:
   i. On or around 5 August 2013;
   ii. On or around 3 February 2015.

b. In relation to Patient F:
   i. On or around 7 May 2013;
   ii. On or around 6 May 2014;
   iii. On or around 8 May 2015;
   iv. A date unknown in May 2016.

a) found proved; b) not proved

Patient J
The Committee noted that the Registrant had been asked about Patient J by Ms A in an early meeting. It noted that the Registrant indicated that he had carried out an assessment of basic binocular vision the first time that he had seen this patient but that by his own admission he had not done this on each occasion he had seen her. The patient records show that Patient J had been seen by the Registrant in 2010.

Patient F
The Committee distinguished the act of undertaking testing from the act of making adequate records. Given the burden and standard of proof and the lack of evidence as to how or whether the Registrant undertook testing, the Committee was not prepared to make the inference that a lack of recording necessarily equate with an absence of adequate testing. Further, the Committee notes that the Registrant indicates that he did do the cover tests but did not always record results.

Particular 17
You failed to make any or any adequate record of any assessment of basic binocular vision:

a. In relation to Patient J:
   i. On or around 5 August 2013;
   ii. On or around 3 February 2015.

b. In relation to Patient F:
   i. On or around 7 May 2013;
   ii. On or around 6 May 2014;
   iii. On or around 8 May 2015;
   iv. A date unknown in May 2016
Found proved.

The Committee was assisted by Dr Harper in his report noting the following:

"Basic binocular vision testing is carried out in only a limited number of the eye examinations and in those instances where a cover test has been carried out, the documentation is unclear (there is no quantification of the result and no indication as to whether the test was completed at distance and/or near).

Omission and/or lack of recording is a particular concern in Patient J, a young child, where there is no evidence an assessment of basic binocular vision status has been undertaken and/or recorded to have been undertaken in a paediatric patient with symptoms, either at the 2013 or 2015 examination.

The omission and/or the lack of recording of binocular status is also a particular concern in Patient F, a significantly hypermetropic patient, with diabetic complications and a subsequent ‘cerebral blood clot’ being noted in May 2016. In my opinion, this omission in patients CB [sic] and BD [sic] fall far below the standard of care expected by a reasonably competent optometrist."

With regard to Patient J, given that the Committee found Particular 16 of the Allegation proved, and that the Registrant did not carry out the assessment he should have done, it follows that the Registrant would not have been able to record findings for assessments not undertaken. For Patient F, while Particular 16 was not found proved, no record of any assessment was made, allowing the Committee to find this particular proved.

**Particular 18:**

You failed to make an adequate record of the findings of the internal and/or external eye examinations:

- a. In relation to Patient G on or around 14 August 2015;
- b. In relation to Patient J:
  - i. On or around 5 August 2013;
  - ii. On or around 3 February 2015.
- c. In relation to Patient K on or around 8 September 2015;
- d. In relation to Patient H on or around 27 October 2015;
- e. In relation to Patient B:
  - i. On or around 12 July 2013;
  - ii. On or around 30 June 2015.
- f. In relation to Patient C:
  - i. On or around 12 June 2013;
  - ii. On or around 16 June 2015.
- g. In relation to Patient D:
  - i. On or around 3 January 2014;
ii. On or around 12 March 2015;
iii. On or around 23 March 2016.

h. In relation to Patient E:
   i. On or around 23 April 2013;
   ii. On or around 4 September 2015.

i. In relation to Patient F:
   i. On or around 7 May 2013;
   ii. On or around 6 May 2014;
   iii. On or around 8 May 2015;
   iv. On a date unknown in May 2016.

j. In relation to Patient I:
   i. On or around 24 October 2013;
   ii. On or around 11 March 2014;
   iii. On or around 21 August 2014;
   iv. On or around 16 March 2015;
   v. On or around 13 August 2015;
   vi. On or around 11 February 2016;
   vii. On or around 10 March 2016.

Found proved.

The Committee in looking at the patient records and Dr Harper’s assessment of these records find that there is evidence that internal/external examinations were undertaken but not adequately recorded, e.g. the use of “NAD” for ‘no adverse diagnosis’ was considered insufficient.

The Committee was assisted by Dr Harper’s report which contained the following view:

“While some note of an external and internal eye examination is consistently documented on the Registrant’s records, and indicative that these procedures were included as part of the examination, there is very poor clarity in the documentation of ocular health status and very limited detail is recorded on specific ocular structures, with the Registrant more often than not reliant on a generic tick or the acronym ‘NAD’, i.e. versus a specific comment on ocular features (e.g. cornea, anterior chamber angle, retinal periphery, macula, optic disc). This lack of both clarity and detail in record keeping for the external and internal eye across all patients and all eye examinations is representative of a serious failing in my view, and one which falls far below the standard expected of a reasonably competent optometrist.”
Particular 19:
You failed to carry out visual fields tests when it was indicated to do so:
   a. On or around 11 March 2014 in relation to Patient I;
   b. On a date unknown in May 2016 in relation to Patient F.

Not found proved.

The Committee was assisted by Dr Harper who had the following to say in his report about the failure to record:

“There are a number of instances where visual fields are omitted and where it might have been required in potentially at-risk patients. Because the Registrant’s assessment of, and/or documentation of, his patients’ general health, their histories and family histories and their symptoms is so limited, it is unclear exactly how many of his patients may have specifically needed basic visual field screening, although there are indications for assessing visual fields in Patient I (when she was referred for an eye examination following a fall in March 2014) and in Patient F (where he presented with a ‘cerebral blood clot’ in May 2016).”

The Committee took the same approach for this particular as it has for other instances in which the allegation is drafted to distinguish the undertaking of testing, with the recording of results. Given that nobody observed the Registrant with these patients, and bearing in mind the burden and standard of proof, the Committee does not find this particular proved.

Particular 20:
20. You failed to make any or any adequate record of visual fields tests carried out:
   a. On a date unknown in May 2016 in relation to Patient F;
   b. On or around 27 October 2015 in relation to Patient H;
   c. On or around 30 June 2015 in relation to Patient B;
   d. On or around 23 March 2016 in relation to Patient D;
   e. On or around 4 September 2015 in relation to Patient E;
   f. In relation to Patient I:
      i. On or around 11 March 2014;
      ii. On or around 13 August 2015;
      iii. On or around 11 February 2016;
      iv. On or around 10 March 2016.

Found proved.
Patient F
The is no record of a visual field test undertaken in relation to Patient F on a date unknown in May.

Patient H
There is no adequate record of the visual field test undertaken in relation to this patient on their visit of 27 October 2015.

Patient B
There is no adequate record of the visual field test undertaken in relation to this patient on their visit of 30 June 2015.

Patient D
There is no adequate record of the visual field test undertaken in relation to this patient on their visit of 23 March 2016.

Patient E
There is no adequate record of the visual field test undertaken in relation to this patient on their visit of 4 September 2015.

Patient I
There are no adequate records of a visual field tests being undertaken for this patient in entries on his visits of 11 March 2014, 13 August 2015, 11 February 2016 and 10 March 2016.

The Committee were further assisted by the report of Dr Harper which stated:

"In all of those instances where visual fields has been carried out…, the documentation of the outcome is insufficient (a tick or the word 'full' or similar is used but without any proper output/quantification or even any idea of which visual field instrument, if at all, was used, i.e. versus some informal manual gross visual field testing). In my view, this latter record keeping failing (in cases Patients H, B,…, E and I) falls far below the standard of care expected by an average competent optometrist"

Particular 21:
You failed to undertake tonometry testing:

a. On or around 12 July 2013 in relation to Patient B;

b. On or around 23 April 2013 in relation to Patient E;

c. In relation to Patient D:
   i. On or around 3 January 2014;
   ii. On or around 12 March 2015.

d. In relation to Patient C:
   i. On or around 12 June 2013;
   ii. On or around 16 June 2015.

e. In relation to Patient I:
i. On or around 24 October 2013;
ii. On or around 11 March 2014:
iii. On or around 21 August 2014;
iv. On or around 16 March 2015.

Not found proved.

The Committee was assisted in this Particular of the Allegation by Ms A. Her evidence was that when she attended the Walker practice on 4 November 2015 in order to conduct a record card review, she noticed that Patient L’s record had been altered in that intra-ocular pressures had been added to the record since her visit in June 2015. In exploring this with the Registrant she was made aware that the Registrant kept a separate book for tonometry testing and recorded results therein. Ms A had sight of this book and was able to verify that information was recorded separately within that book rather than being placed immediately onto patient record cards. Given this evidence of an alternative way of recording details, without direct observation to verify or otherwise, whether tonometry testing was taken in these cases, and taking into account the burden and standard of proof, the Committee is not satisfied that the Registrant failed to undertake the tonometry testing alleged.

Particular 22:

22. You failed to make any record of tonometry testing:
   a. On or around 12 July 2013 in relation to Patient B;
   b. On or around 23 April 2013 in relation to Patient E;
   c. In relation to Patient D:
      i. On or around 3 January 2014;
      ii. On or around 12 March 2015.
   d. In relation to Patient C:
      i. On or around 12 June 2013;
      ii. On or around 16 June 2015.
   e. In relation to Patient I:
      i. On or around 24 October 2013;
      ii. On or around 11 March 2014:
      iii. On or around 21 August 2014;
      iv. On or around 16 March 2015.

Not found proved.
From the evidence of Ms A, the Committee is aware that a book for recording tonometry test results exists. This book was viewed by Ms A. Given that this particular of the Allegation is drafted to indicate a failure to make “any record” rather than, ‘any adequate record’ and taking into account the burden and standard of proof, the Committee was not satisfied that it had sufficient evidence to find this particular proved.

**Particular 23:**

On a date unknown between 25 June 2015 and 4 November 2015 you added to the record of Patient L's examination of 24 March 2015 intra ocular pressure scores.

**Found proved.**

Ms A exhibits photographs of the records taken at each visit to the Walker practice. She noted that there had been an addition to Patient L’s record card, in that intra ocular pressure scores had been added by 4 November 2015, but which had not been present at her visit of 25 June 2015. Ms A recounts a meeting with the Registrant where she asked the Registrant about this and it was accepted by the Registrant that this addition had been made.

**Particular 24:**

You failed to maintain an adequate standard of record keeping:

a. Patient A on or around 18 March 2016;

b. Patient G on or around 14 August 2015;

c. Patient J between around 5 August 2013 and around 3 February 2015;

d. Patient K on around 8 September 2015;

e. Patient H on or around 27 October 2015;

f. Patient B between around 12 July 2013 and around 30 June 2015;

g. Patient C between around 12 June 2013 and around 16 June 2015;

h. Patient D between around 3 January 2014 and around 23 March 2016;

i. Patient E between around 23 April 2013 and around 4 September 2015;

j. Patient F between around 7 May 2013 and around 31 May 2016;


**Found proved on the following basis:**

b. Patient G: 9a, 13a, 15a, 18a

c. Patient J: 13b, 15b,

d. Patient K: 13c, 15c, 18c.

e. Patient H: 9b, 11a, 15d, 18d, 20d
f. Patient B: 7a, 11b, 13d, 15e, 18e, 20c in relation to 30 June 2015 only.
g. Patient C: 7b, 11c, 13e, 15f
h. Patient D: 7c, 11d, 13f, 15g, 18g, 20d
i. Patient E: 7d, 11e, 13g, 15h, 18h, 20e
j. Patient F: 7e, 11f, 13h, 15i, 17b, 18i, 20a
k. Patient I: 11g, 13i, 15j, 18j, 20f

Given the omissions that the Committee has noted in relation to record keeping for Patients G, J, H, B, C, D, E, F and I, in different particulars of the Allegation, the Committee finds the Registrant’s record keeping was not adequate for these 10 patients. In determining what an adequate standard was, the Committee was assisted by the evidence of Dr Harper. In his report at paragraph 5.2.12.6, Dr Harper set out his opinion:

"The Registrant’s eye examination records are very poor in terms of legibility and overall clarity, an essential criterion for record keeping in healthcare. The lack of legibility and clarity in record keeping falls far below the standard expected of a reasonably competent optometrist for each individual patient reviewed, with the overall status of record keeping in this respect being quite shockingly poor across these 10 patients."

Findings in relation to deficient professional performance and/or misconduct.

The Committee heard submissions on behalf of the Council to explain that deficient professional performance and misconduct were offered as alternative statutory grounds. It was submitted that either ground could be found for each fact, and the Committee could consider the failings one by one, or taken as a whole. It accepted the advice of the Legal Adviser.

The Committee considered whether the facts found proved amounted to misconduct and/or deficient professional performance. The approach the Committee took distinguished the circumstances observed surrounding Patient A’s treatment, (particulars 1-5 of the Allegation), from that of the ten other patients whose records alone were considered, (at particulars 6-24 of the Allegation). This was because the evidence that allowed facts to be found proved for Patient A relied on direct observation. In the observation of Patient A’s treatment, there was evidence that the Registrant could not adequately carry out ophthalmoscopy, intra ocular pressure test recording, or visual field testing. These matters are serious and fundamental to practise as an optometrist. The remaining ten patients’ records which were reviewed, were found to be missing information that was important for their current and future care and for any other optometrist who would take over their care. Not making an adequate record and adding to a record at a later date without proper explanation, or justification, meant that the patient records created by the Registrant could not be relied upon.
The Committee determined that the Registrant’s conduct, whether by wilful neglect, or recklessness, was far below that of a reasonably competent optometrist.

The Committee identified the statutory ground of misconduct as being met. The gravity of the Registrant’s failure and the possible consequences of his failures meant that there was a risk to patients. This was serious and the facts found proved collectively amounted to misconduct.

In considering the facts, the Committee identified that the failings were in several categories, namely a failure to take an adequate patient history, failure to make an adequate record, (including the accurate recording of intraocular pressure results from tonometry testing), and failure to adequately carry out necessary diagnostic tests including ophthalmoscopy, visual field tests and basic binocular vision assessment.

The Committee did also consider the facts found proved individually. For Patient J, the Registrant failed to carry out any assessment of basic binocular vision. For Patient A at particulars 1-5, it had found an inability to undertake tests adequately, an inability to use the necessary equipment correctly, a failure to take an adequate history, and a lack of recording. The lack of adequate recording details was widespread, covering different types of information:

- At Particular 7: visual status;
- At Particular 9: presenting symptoms and/or reason for visit;
- At Particular 11: visual requirement in relation to work and/or other activities/ and/or driving;
- At Particular 13: general health and/or medication;
- At Particular 15: patients’ ocular and/or family ocular history;
- At Particular 17: test results for basic binocular vision;
- At Particular 18: internal and external eye examination results;
- At Particular 20: visual field test results;

While the Committee had not been satisfied that the evidence supported a finding that tests and enquiries were not undertaken on the basis only that records had not been made, the Committee did find a failure to adequately record findings, (including the accurate recording of intraocular pressure results from tonometry testing), and this is in itself serious. This combined with its other major concerns, such as the Registrant’s failure to conduct an adequate examination of the fundus mean that misconduct is found proved.

The Committee was satisfied that a finding of misconduct is justified in this case, given that the Registrant’s inability to conduct basic optometric testing means that a safe eye test may not be possible. This is exacerbated by the failure to record details to such an extent that the records were described by Dr Harper as far below the standard required in many respects, and collectively would, “shock any optometrist taking over his practice”. The records examined demonstrate the Registrant’s multiple failings in respect of numerous patients in fundamental areas of practice. These continued over a period of years.
The Registrant has breached the Code of Conduct for Individual Registrants 2010. In particular, in respect of all patients, he has failed to:

- 1. Make the care of the patient your first and continuing concern;
- 6. Maintain adequate patient records;
- 8. Keep professional skills and knowledge up to date;
- 19. Ensure your conduct, whether or not connected to your professional practice does not damage public confidence in you or your profession.

Given that a new Standards of Practice (“SOP”) was published in April 2016, this is breached in relation to Patient F who was seen by the Registrant in May 2016. The Registrant has breached the SOP:

- 5. Keeping your knowledge and skills up to date;

In all the circumstances the Committee found that the facts found proved amount to misconduct. While a minor recording omission alone may have only amounted to deficient professional performance, the composite picture made this conclusion inappropriate.

Findings regarding Impairment

Having made a finding of misconduct the Committee then went on to determine whether or not, in light of that misconduct, the fitness to practise of the Registrant was currently impaired. This involved the Committee exercising its professional judgement. Mr Corrie on behalf of the Council invited the Committee to make a finding of current impairment. He referenced the lack of evidence of remediation on the part of the Registrant.

The Committee accepted the advice of the Legal Adviser. The Legal Adviser referred the Committee to the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin) (“Grant”) and in particular paragraph 76 where Mrs Justice Cox approved of the following test:

“Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

(a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

(b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

(c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

(d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.”

The Legal Adviser also referred to the public interest consideration in the case of Grant as well as the case of Cohen v GMC [2008] EWHC (Admin) 581.
The Committee acknowledged that little had been said on behalf of the Registrant. There had been correspondence from his family members that he had retired and had no intention of practising in the future. It considered that there was no evidence of any insight displayed by the Registrant in respect of any of the particulars of the Allegations that resulted in a finding of misconduct. Whilst the Registrant engaged with Ms A, he has not sought to put any relevant material before the Committee for the purposes of this hearing.

The Committee considered that there had been no evidence of any attempts at remediation and there was therefore a future risk that the behaviour that gave rise to the charges would be repeated. The Committee notes that the Registrant has expressed no remorse for his actions or omissions in general.

The Committee had been advised that the Registrant has not practised for three years. The Committee has no evidence that the Registrant has maintained his professional skills in this period. Were the Registrant to decide to return to practice, the Committee concluded, bearing in mind that the failings found proved in each of the patients records reviewed was inadequate, that the Registrant’s practice falls far below the required standard, and that there exists a real risk of repetition of those particulars relating to both recording failures, and an inability to use equipment necessary for sight tests.

The Committee considered that limbs (a) (b) and (c) in the case of Grant were engaged. While there has been an indication that the Registrant does not intend to practise in the future, the Committee must consider whether the Registrant's fitness to practise is currently impaired. It further considered that the Registrant’s acts and omissions amounted to a pattern of behaviour and had breached fundamental tenets of the profession, which has the potential to bring it into disrepute.

The Committee considered that a finding of current impairment on the grounds of public protection and the public interest is necessary, given the absence of any remediation and given that the Committee has found there is a risk of repetition of the misconduct. The Committee then considered whether a finding of impairment was also necessary to maintain public confidence in the profession. The Committee was in no doubt that the Registrant’s past actions did bring the profession into disrepute and given the seriousness of the misconduct identified, that public confidence in the profession would be seriously damaged if a finding of current impairment was not made.

The Committee therefore satisfied that the fitness to practise of Mr Bryan Ainley is currently impaired.

Sanction

The Committee has heard submissions from Mr Corrie on behalf of the Council. He pointed out the Registrant’s limited engagement and submitted that the Registrant had demonstrated no insight. Mr Corrie sought an order of erasure, with some reluctance, stating that the Registrant’s conduct was fundamentally incompatible with ongoing registration. It has accepted the advice of the Legal Adviser.

Prior to considering which sanction, if any, to impose the Committee started by assessing the mitigating and aggravating factors.

It considered the following to be mitigating factors:
The Registrant has had a long career dating back to 1962 without any previous disciplinary history;

There have been no complaints or evidence of actual patient harm resulting from the Registrant’s misconduct.

It considered the following to be aggravating factors:

- The Registrant had displayed no evidence of insight;
- The misconduct was in the course of professional practice;
- The deficiencies in patient records were apparent in each of the records sampled indicating widespread poor practice;
- There appeared to be an inability to perform adequately the most basic components of an eye examination;
- That patients were placed at risk by having inadequate records created for them by the Registrant.

The Committee bore in mind that the purpose of imposing a sanction is to guard against risk identified in relation to protecting the public and the public interest rather than simply impose a punishment for wrongdoing. It considered whether to take no further action but found there to be no exceptional circumstances that would justify taking such a course. Such a sanction would not be in the public interest or provide protection to the public. The Committee considered the sanctions available to it from the least necessary to the most severe, applying the principle of proportionality.

The Committee then went on to consider Conditional Registration. It determined that conditions would be inappropriate as there are no workable conditions that could be formulated in this case, given that it had no assurances that the Registrant would comply with any conditions imposed. He is presently not in practice, nor has he provided any evidence of intention or activity to remediate the deficiencies identified in his practice. In these circumstances, the Committee concluded that imposing any order of conditions would not adequately protect the public or the public interest.

The Committee next considered whether or not to suspend the Registrant. It had regard to part 34 of the GOC Guidance on Sanctions. The Committee reminded itself that this was a serious instance of misconduct involving repeated acts of very poor record keeping and a failure to adequately conduct an eye examination, putting patients at risk. The Committee considered that while there has been no repetition of events since the investigation began, this appears to be as a result of the Registrant having retired following the NHS investigation rather than as a result of any insight into failings and remediation occurring. On the information available, the Committee was not satisfied that the Registrant had insight and did not pose a significant risk of repeating behaviour. Accordingly, the sanction of suspension was neither adequate nor sufficient in all the circumstances.

The Committee considered whether an erasure order was required. It considered the terms of part 36.5 of the GOC Guidance on Sanctions. The Committee was satisfied that the Registrant’s misconduct was a serious departure from the relevant professional standards with the potential for serious patient harm. The deficiencies in practice had not been remediated, nor any interest in addressing these
expressed. Accordingly, the Committee concluded that if the Registrant were to return to practice, he would pose a risk. The Committee concluded that the Registrant’s failures, given their breadth and lack of remediation are fundamentally incompatible with practice. Were the Registrant to return to practice, there would be a risk of serious harm to individuals. Further, the Registrant has not been able to demonstrate either insight into his repeated failures or its consequences. The failure to provide an acceptable level of patient care, (including both clinical failures and record keeping for many years), without remediation, leaves the Committee with no confidence that the Registrant has the potential to develop insight into his failures and learn from them. Accordingly, the only appropriate and proportionate sanction is one of erasure.

The Committee considered that this order was necessary to protect the public, mark the importance of maintaining public confidence in the profession and to send to the public and the profession a clear message about the standard of conduct required from members of the profession.

The Committee noted that such an order may potentially adversely impact the Registrant but concluded this is outweighed by the public interest in this case.

[Submission regarding the drafting of paragraph 89 from the Council:

Mr Corrie on behalf of the Council raised an issue with the drafting of one sentence within paragraph 89 of their determination. He observed that the Committee has drafted the phrase that, “the failure to provide an acceptable level of patient care for many years,” was potentially ambiguous, given the way that the particulars of the Allegation were drafted, distinguished clinical care issues from record keeping failures. He said that while particulars 1,2,3, 5 and 16, i-ii) in relation to Patient J, relate to patient care, the other particulars are about record-keeping failures. The Committee considered that paragraph 64 (paragraph 2 of findings in relation to deficient professional performance and/or misconduct) of their determination already made a link between patient care and acceptable records. However, for the avoidance of any doubt, the insertion of a phrase to clarify that record keeping is an important part of patient care is made.]

Immediate Order

The Committee heard submissions from Mr. Corrie on behalf of the Council for an immediate order of suspension. It accepted the advice of the Legal Adviser who directed it to section 13i of the Opticians Act 1989, as amended, and the Sanctions Guidance. The Committee had regard to the seriousness of the misconduct as detailed in the Allegation and the reasons set out in its decision for the substantive order to protect members of the public and in the public interest to uphold the reputation of the profession and to mark the very serious nature of the Registrant’s misconduct. To do otherwise would be incompatible with its earlier findings.

This order will remain in place for 28 days from today’s date or until any appeal is determined.

Revocation of interim order

The Committee hereby revokes the interim order of suspension.
Chair of the Committee: Valerie Paterson

Signature .................................................. Date: 14 June 2019

Registrant: Bryan Ainley

Signature Registrant not present to sign Date: 14 June 2019
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. PSA is required to make its decision within 40 days of the hearing (or 40 days from the last day on which a registrant can appeal against the decision, if applicable) and will send written confirmation of a decision to refer to registrants on the first working day following a hearing. 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.

European Alert
The General Optical Council is required by Regulation 67 of the European Union (Recognition of Professional Qualifications) Regulations 2015 to inform all European competent authorities of any restrictions or prohibitions on a dispensing optician or an optometrist’s practice. ‘Competent authority’ effectively means the relevant regulator for each EU member state.

The GOC is the competent authority for all opticians registered in the United Kingdom (UK).
If you have been made subject to either a suspension or conditions of practice order (whether interim or substantive), or to an erasure order, we hereby notify you of the following:

Within 3 days of the Fitness to Practise Committee decision taking effect you will be the subject of an alert sent under article 56a(1) of the Directive; You have the right to appeal the decision to issue the alert or to apply for rectification of the decision; and You have the right to access remedies in respect of any damage caused by false alerts sent to other competent authorities.

The alert is sent securely via the Internal Market Information (IMI) system. The alert will include the following details:

- Your identity (full name and date of birth);
- Your profession;
- Your GOC registration number;
- The fact that the GOC is the national authority which adopted the decision on the restriction or prohibition of your professional activities;
- The scope of the restriction or prohibition;
- The period during which the restriction or the prohibition applies.

If you wish to appeal the decision to issue this alert then please see the information sheet below. Please note that this relates to your right of appeal against the issuing of the alert – see above regarding your right of appeal against a substantive decision.

A copy of the alert may be obtained via the contact details at the end of this document.

Please see the attached information sheet for further information.

**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.
European Alert – Information Sheet

Please see the below Frequently Asked Questions (FAQs) which have been developed to assist you with this process and explain your options.

1. **Why has the General Optical Council (GOC) sent this alert?**
   With effect from 18 January 2016 the GOC is legally required to issue alerts concerning all registrants whose practice has been prohibited or restricted – this includes all determinations of suspension, conditions or erasure issued by a Fitness to Practice Committee (FTPC), whether interim or substantive, and any extensions ordered by the High Court.

   This legal requirement is placed on us by article 56a of Directive 2005/36/EC on the recognition of professional qualifications (‘the Directive’). This article was adopted into UK legislation via Regulation 67 of the European Union (Recognition of Professional Qualifications) Regulations 2015. All other Member States must also comply with the provisions of the Directive and participate in the alert mechanism.

2. **What is the purpose of these alerts?**
   The purpose of these alerts is to ensure public protection across all Member States. The intention is that each member state will be notified of any restrictions or prohibitions placed on UK registrants so that they are able to check this against their own registers and applicants. We will also be notified of any restrictions or prohibitions handed down to European optical professionals. This will assist us with safeguarding the public and maintaining the integrity of our registers.

3. **Why was I not consulted before the alert was sent?**
   The terms of the Regulations are very strict; the alert must be issued within three days of the panel’s decision coming into effect. The notification must be issued at the same time the alert itself is sent.

4. **Who will see the alert?**
   The alert is sent securely via the Internal Market Information (IMI) system to the competent authority in each Member State.

   In the UK, statutorily regulated health and social care professionals have to be registered with, and show that they meet the standards of, the relevant regulatory body, in order to practise their profession. The regulators control access to regulated professions, professional and vocational titles and professional activities which require specific qualifications, and are subject to national law. The European Commission term these organisations the ‘competent authorities’ although the exact duties of the competent authorities vary across member states, they are effectively the regulator (in the same way the GOC is) for each member state.

   A competent authority has been defined by the European Commission as: *any authority or body empowered by a Member State specifically to issue or receive training diplomas and other documents or information and to receive the application and take the decision, referred to in Directive 2005/36/EC.*

5. **If there is a mistake in the alert can I apply for it to be corrected?**
   If you notice a mistake in the alert (such as a typing error or incorrect information) then please contact the GOC and we will consider your request to amend the alert. Please
6. What if I disagree with the alert being sent?
If you disagree with the sending of an alert then you have the right of appeal to the County Court. If you merely consider there to be a mistake within the alert then please refer to the above question.

Please note that the GOC is required to send the alert under European Law. With this in mind, and if you still wish to appeal to the County Court, then you may find the following government website useful: https://www.judiciary.gov.uk/you-and-the-judiciary/going-to-court/county-court/

If you attended the hearing and were given the FTPC decision document by hand then the period for submitting an appeal with the County Court is 28 days from the date you were handed the document. If the FTPC decision document has been sent to you by post, the appeal period is 30 days from the date the decision document was posted to you (there is an additional 2 days allowed to cover postage time).

7. Can the GOC assist me with my appeal against the issuing of an alert?
The GOC is unable to help you with your appeal – we strongly advise that you seek independent legal advice.

8. If I appeal an alert being sent, what effect will that have on the substantive decision made in relation to my registration?
There will be no effect on the decision made by the GOC affecting your registration. This would be an appeal against the issuing of the alert and not the substantive decision – they are two separate things and each have different appeal routes. If you require details on how to appeal the substantive decision (i.e. the erasure, conditions or suspension) then please refer to the separate guidance sheet enclosed with the decision letter regarding your substantive GOC case.

9. If I successfully appeal the issuing of an alert, what will happen to the alert itself?
While your appeal is ongoing the alert will remain on the IMI system but with a qualification to say that an appeal has been lodged.

On appeal the County Court may:
- Dismiss your appeal;
- Allow your appeal and direct the alert be withdrawn or amended accordingly.
  If the County Court decide to allow the appeal then the GOC has a duty to delete the alert (or amend as appropriate) within three days of this decision.

10. What happens if the order made by the FTPC is revoked?
When an order is revoked by the FTPC (or the High Court) and that order was the subject of a European alert, we will close the alert within 3 days of the decision to revoke the order. When an alert is closed, all personal data is removed from the a...