BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(19)09

AND

ARIF CHANAWALA (01-21154)

DETERMINATION OF A SUBSTANTIVE HEARING
10-13 March, 16-19 March and 10-12 June 2020

Committee Members:	Mr Graham White (Chair/Lay) Ms Sarah Hamilton (Lay) Ms Victoria Smith (Lay) Mr Gordon Elliott (Optometrist) Ms Denise Connor (Optometrist)
Clinical adviser:	N/A
Legal adviser:	Mr G Henderson
GOC Presenting Officer:	Mr M Corrie
Registrant present/represented:	Present and represented
Registrant representative:	Mr A McGee instructed by Ms S Masud (AOP)
Hearings Officer:	Ms A Shabini & T Yates
Facts found proved:	1,2,3,4,6,7,8,9,11,12,13 &14 (By admission) 5(b) &15
Facts not found proved:	5(a) & 10
Misconduct:	Found
Impairment:	Impaired
Sanction:	Erasure

Immediate order:	Yes

ALLEGATION

"The Council alleges that you, Mr Arif Chanawala, a registered Optometrist:

1. Between around 3 and around 11 June 2015 you carried out sight tests on pupils at the [redacted] School as set out in Schedule A when you were not authorised to do so by National Health Service England.

2. Between around 9 July and 15 July 2015 you carried out sight tests on pupils at the [redacted] School as set out in Schedule B when you were not authorised to do so by National Health Service England.

3. In relation to the sight tests referred to at 1 and/or 2 above you failed to carry out adequate sight tests.

4. You submitted GOS6 forms in claim for payment for mobile funded National Health Service eye tests in respect of the examinations carried out at 1 and/or 2 above when you were not entitled to payment for the sight tests.

5. Your actions at 4 above were dishonest in that:

    a. You knew you were not entitled to payment for mobile funded National Health Service Eye tests for sight tests conducted at a school; and/or

    b. You knew you were not entitled to payment because you knew and/ or suspected that you had not carried out adequate sight tests.

6. In relation to the sight tests carried out at [redacted] School between around 9 and around 15 July 2015 you failed to obtain informed consent in that:

    a. You followed an opt out process; and/or

b. In the consent letter sent to the patients' parents or guardians you described the procedure proposed to take place as being part of a screening programme; and/or

c. You did not provide adequate information as to the actions and/or possible outcomes of a sight test.

7. In relation to the sight tests carried out at [redacted] School between around 3 and around 11 June 2015 you failed to obtain informed consent in that:

a. In the consent letter sent to the patients' parents or guardians you described the procedure proposed to take place as being part of a screening programme; and/or

b. You did not provide adequate information as to the actions and / or possible outcomes of a sight test.

8. In relation to the sight tests carried out at 1 and/or 2 above you failed to ensure that there was an adequate system in place to request and/or obtain the following information prior to the sight tests:

a. History; and/or

b. Symptoms; and/or

c. Ocular history; and/or

d. Family ocular history; and/or

e. General health;

f. The date of the last sight test.

9. You failed to maintain an adequate standard of record keeping in that the number of claims submitted to the National Health Service for payment did not match up to the number of clinical records.

10. You failed to take adequate steps to inform the patients' parents or guardians of the outcome of the sight tests in that the letters of outcome of the sight tests were given to the children rather than the parents or guardians.

11. You caused or allowed outcome letters to state that that the child's vison was good and their eyes were healthy when the clinical record stated that it had not been possible to measure visual acuity, in relation to the patients set out in Schedule C.

12. Your actions at 11 above were misleading.

13. You failed to make a referral when it was clinically indicated to do so in relation to the patients set out in Schedule D.

14. On or around 10 September 2015 you stated to representatives of NHS England words to the effect that the initial contact in relation to the sight tests 1 and/or 2 above had been made by the respective schools.

15. Your actions at 14 above were dishonest in that:

    a. The initial contact had been made by the [redacted] Clinic; and/or

    b. At the time you made the statement at 14 above you were aware that it was not correct.

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

The Schedules to the allegation make reference to a number of pupils in anonymised form

Schedule A lists 210 pupils

Schedule B lists 416 pupils

Schedule C Lists 6 pupils

Schedule D lists 28 pupils

DETERMINATION

Admissions in relation to the particulars of the allegation

At the outset of the hearing the Registrant admitted Particulars 1, 2, 3, 4, 6, 7, 8, 9, 11, 12, and 14 of the allegation. These facts were announced as having been proved by way of admission.

It was indicated that discussions were taking place with regard to Particular 13. Following the production of a Supplementary Expert Report, at the start of day 2 of the hearing, the Committee was informed that the Registrant admitted particular 13. The facts of Particular 13 were announced as being proved by way of admission. Although the Registrant admitted part (a) of Particular 15 he did not admit the stem.

Background to the allegations

The Registrant is a Registered Optometrist who at the time of the allegation, was providing services as the sole Director of a Company whose legal name was [redacted] and whose trading name was [redacted] (the Practice).
The Registrant provided sight tests for the NHS through two Contracts. He had a General Ophthalmic Mandatory Services Contract (Mandatory Contract). The Mandatory Contract permitted him to provide NHS services from his place of business in the high street. He also had a General Ophthalmic Additional Services Contract (Additional Services Contract). The Additional Services Contract permitted him to provide NHS services to patients who are unable to attend or access high street services.

On 4 December 2014 an email was sent by the Practice to [redacted] School [(redacted)]. In that email an offer was made by the Practice to provide free eye tests as "part of the national Child's Health program". What was offered was a "full NHS sight test".

[redacted] responded to the email by expressing an interest and arrangements were made for tests to be carried out at the school. The Practice sent a number of documents to [redacted] including a consent letter. In that consent letter reference was made to the Practice "running a visual screening programme at the School". At the foot of the consent letter the parent/ guardian was required to give permission for their child "to attend to have his/her eyes screened at the school."

The Registrant attended [redacted] on 3 and 11 June 2015 and carried out sight tests on around 210 children.

On 26 June 2015 an email was sent by the Practice to [redacted] School [(redacted)]. In that email an offer was made by the Practice to provide free eye tests by way of a "full NHS Sight Test."

[redacted] also responded to the email by expressing an interest and arrangements were made for tests to be carried out at [redacted]. The Practice sent a number of

documents to [redacted] including a consent letter. In that consent letter reference was made to the Practice "running a visual screening programme at the School". At the foot of the consent letter the parent/ guardian was required to notify the practice if they did not wish to have their eyes "screened".

The Registrant attended [redacted] on various days from around 9 to around 15 July 2015. He carried out sight tests on around 416 pupils.

Although she had no specialist knowledge the administrator at [redacted] considered the length of the examination of each individual pupil to be shorter than she would have expected.

Following his examination of the pupils at these schools the Registrant submitted claims to the NHS Shared Business Services (NHS SBS). He sought payment for 626 eye examinations – 210 for [redacted] and 416 for [redacted]. The claim forms were submitted on 27 June and 27 July 2015 respectively. The claim forms contained declarations, signed by the Registrant, that the information contained in the form was correct and complete. The forms were submitted on the basis that the Registrant was not claiming for the domiciliary element of the fee.

NHS SBS refused to make payment on the basis that it was under no contractual obligation to do so having taken advice from NHS England.

The Registrant now accepts that he carried out tests in these schools when he had not been authorised by the NHS to do so (Particulars 1 and 2). He has admitted that he submitted claims in respect of these tests when he was not entitled to payment (Particular 4).

Concerns were also raised in respect of the quality of tests that had been carried out. In particular it would not have been possible for him to conduct adequate sight tests in the limited period of time that he had afforded to each pupil. The Registrant accepts that he failed to carry out adequate sight tests (Particular 3).

The Registrant also accepts that he failed to obtain informed consent from the parents/ guardians of the pupils at the schools that he visited.

In respect of the consent form for [redacted] he accepts that he: followed an opt out process; described the proposed procedure, in the consent letter, to be part of a "screening programme" and did not provide adequate information as to the actions and possible outcomes of a sight test (Particular 6).

In respect of the consent form for [redacted] he accepts that he: described the proposed procedure, in the consent letter, to be part of a "screening programme" and did not provide adequate information as to the actions and possible outcomes of a sight test (Particular 7).

The Registrant also accepts that, in respect of the sight tests carried out at these Schools, he failed to ensure that there was an adequate system in place to request and/ or obtain a number of items of essential information (Particular 8).

The Registrant accepts that he failed to maintain an adequate standard of record keeping in that the number of claims submitted to the NHS did not match up with the number of clinical records (Particular 9).

The Registrant accepts that he caused outcome letters to be issued stating that the child's vision was good and that their eyes were healthy when, in the case of 6 pupils it had not been possible to measure visual acuity (Particular 11). He also accepts that this was misleading (Particular 12). In addition, he accepts that he failed to make a referral in respect of 26 pupils when it was clinically indicated to do so (Particular 13).

Following the submission of GOS6 claim forms to the NHS, for his work at these schools, his claim was refused, and an investigation was commenced. The Registrant accepts that on or around 10 September 2015 he told Representatives of NHS England that initial contact in relation to both schools had been made by the schools (Particular 14).

Findings in relation to the facts

Mr Corrie, on behalf of the Council, invited the Committee to find the remaining particulars proved.

Mr McGee, on behalf of the Registrant invited the Committee to the find the remaining particulars not proved.

The Committee had regard to the advice provided by the Legal Adviser and accepted that advice.

The Committee was aware that the burden of proof was on the Council and that the standard of proof was the civil standard.

The Committee heard live evidence from three witnesses; [redacted] who was, at the material time a business manager with NHS SBS; Richard Booth who provided Expert Evidence and Expert Reports for the Council: and the Registrant.

The Committee also took into account the evidence contained in witness statements that were not the subject of challenge. These were: [redacted] – Lead Optometry Advisor NHS England; [redacted] – a Partner in [redacted] LLP; [redacted] - at the time a Data Processor with NHS SBS; [redacted] – Inclusion Lead, [redacted]; [redacted] – Administrative Assistant, [redacted; [redacted] – Assistant Head Teacher Inclusion and Special Needs Coordinator, [redacted].

The Committee also had regard to the documentary evidence submitted as well as listening to a recorded telephone call between [redacted] and the Registrant.

There was no challenge to the credibility and reliability of the witnesses led by the Council. The Committee considered [redacted] to be a credible and reliable witness who was understandably unable to recall details of some past events and who made appropriate concessions when matters were put to him in cross examination. The Committee were satisfied that Mr Booth was a helpful expert witness who was well qualified to speak of matters within his expertise.

The Committee had concerns regarding the credibility and reliability of the evidence of the Registrant and found his answers to a number of questions to be evasive.

Particular 5

The Council claim that the submission of claim forms was dishonest for two reasons:

They claim that the Registrant knew he was not entitled to payment for sight tests conducted at a school. They also claim that he knew he was not entitled to payment because he knew or suspected that he had not carried out adequate sight tests.

It was submitted, on behalf of the Council, that the Registrant knew that he was not entitled to claim for tests carried out at schools because there were two documents that he would have had regard to which made it clear that school visits could not be claimed for through the NHS.

Reference was made to Guidance issued to members of the Association of Optometrists (AOP) which the Registrant accepted that he had received and probably read. This Guidance – "Making Accurate Claims in England", was issued in May 2014. Part 11 which deals with Domiciliary Visits to Day Centres states "Schools, secure units and prisons are not considered to be day centres". In the introduction to the guidance it is stated "This document is informal guidance and is not an authoritative interpretation of the law. In cases of uncertainty, please contact your NHS England Area Team…"

Although reference was made to the Additional Services Contract, the Committee was not directed to any particular provision of it. The contract contains no express provision making it clear that school visits are excluded. The scheme of the contract is for there to be visits to patients who would not be able to access high street Optometrists. The Contract envisages that there will be visits to the patient's home, residential centre or "day centre". A "day centre" is defined as "an establishment… attended by eligible persons who would have difficulty in obtaining sight testing services by way of mandatory services by way of mental illness or disability …."

The Committee reminded itself that it was required to consider the state of mind of the Registrant when he submitted the claim forms and was not satisfied that the Council had proved its case.

The Committee had particular regard to the evidence of [redacted] and that of the Registrant. The evidence of [redacted] was to the effect that he thought it was permissible for sight tests to be carried out in schools provided that the pupil would have difficulty in obtaining sight tests in high street establishments. He would have expected a primary school to have had half a dozen such pupils. His concerns, regarding the claim forms, were that too many pupils had been tested. The Committee considered that the evidence of [redacted] was based on one possible interpretation of the contract.

The Committee also had regard to the Registrant's evidence that he had been visiting schools and subsequently submitting unchallenged claims for sight tests since 2012

which openly stated the name of the school. He was advised that pre notification was not required and, whilst he was entitled to claim the test fee, he was not entitled to claim the domiciliary element of the fee. Mr [redacted] was the Registrant's regular point of contact with the NHS. Mr Booth accepted that it was reasonable for the Registrant to act on that advice. Since the AOP Guidance is informal and envisages contact with the NHS, knowledge of the guidance was not enough to satisfy the Committee that the Registrant was aware that there was a blanket prohibition of making claims for school visits.

In light of these factors the Committee did not find part (a) of Particular 5 proved.

The Committee then considered part (b) of Particular 5. The Committee had to consider whether the Registrant knew that he was not entitled to payment because he knew or suspected that he had not carried out adequate sight tests.

In accordance with the test set out in Ivey v Genting Casinos [2017] UKSC 67 the Committee first considered the state of the Registrant's mind at the time he submitted the forms

The Committee had regard to the fact that the Registrant admitted, in live evidence, that he spent far less time on each sight test than he would when examining patients in his premises. In addition, the Committee had regard to the Report submitted by [redacted] which noted that the Registrant claimed for 134, 74,185, 145, and 76 pupils respectively per day. Even allowing for the Registrant having worked without taking lunch and other breaks the Committee did not consider that he had sufficient time to perform adequate tests.

In his live evidence the Registrant accepted that he knows now that the testing was inadequate but he did not know this at the time. The Committee did not consider this evidence to be plausible. The Registrant told the Committee that he would receive details of the patients he was allocated to see for testing, in advance of attending the schools. He would have been well aware of the numbers of children that were being allocated and the insufficient amount of time available to test them in an adequate manner. As the only professional present, he ought to have taken steps to control numbers.

The Committee was satisfied that the Registrant was well aware, at the time he submitted the GOS6 forms that he knew he had not carried out adequate sight tests.

The Committee also found that the submission of GOS6 forms would, in these circumstances be regarded as dishonest in the minds of right thinking ordinary people.

The Committee found Particular 5 (b) proved.

Particular 10

The Committee had regard to all of the evidence and agreed with the submissions, made by Mr McGee on behalf of the Registrant that the Particular was based on a misunderstanding of what had been given to the children at the end of the eye examination.

The Committee did not consider the document given to the children at the end of the test to be an outcome letter. It accepted the evidence of the Registrant that he delivered outcome letters to the school reception at a far later date. It noted that [redacted] School stated that outcome letters had been delivered to them in September and would not have been received by Year 6 pupils who had left for secondary school by then. The decision of how to distribute the letters would have been made by the schools and the Committee found it reasonable to assume that a school would do this in a manner that meant parents would receive these letters.

Having had regard to the precise wording of the Particular the Committee was not satisfied that the Council had discharged its burden of proof. It found Particular 10 to be not proved.

Particular 15

The Registrant accepts that, on or around 10 September 2015, he met representatives of NHS England and stated words to the effect that initial contact in relation to the sight tests had been made by the respective schools. He now accepts that the initial contact had been made by his clinic. The Committee was required to consider whether he had been dishonest in providing this incorrect statement.

The Committee had regard to the background circumstances. The Registrant would have been aware that there was a problem with his claim for sight tests in August 2015. He would have had time to investigate the facts. Although there are no minutes of the meeting on 10 September 2015, NHS England wrote to the Registrant in a letter dated 28 October 2015 stating what had taken place at the meeting. This evidence was accepted as fact by the Registrant. The Committee noted, from that letter, that the Registrant claimed to NHS England that “the sight tests did not take long on average, 20 minutes.” The Registrant also claimed that there were 2 to 4 staff present. These claims were contradicted by his live evidence that he was only ever assisted by one administrator.

The Registrant was unable to provide the Committee with a credible explanation for his misrepresentation of the factual position. Had he not known who had made the initial contact it would have been open for him to say that he did not know. The Committee considered what the Registrant’s state of mind was at the meeting. It concluded that he knew full well that he was providing incorrect information in an attempt to make the situation appear more favourable to him.

The Committee considered that the Registrant’s actions set out in Particular 14 would be regarded as dishonest in the minds of right thinking people.

Accordingly, Particular 15 is proved in its entirety.

Application for clarification of Findings in Fact

Following the announcement of its Findings in Fact the Committee provided the parties with written reasons for its findings in terms of Rule 46 (11) of the General Optical Council Fitness to Practise Rules (2013) (The Rules).

Having afforded the parties time to read the determination a joint application was made, that the Committee should clarify its determination in respect of one aspect. It was submitted that the Committee had the power to do so at common law.

The Committee heard and accepted the advice of the Legal Adviser who referred the Committee to Rule 46 (1). He suggested that Rule 46 (1) provided the Committee with an express power to innovate on procedure when it was just and appropriate to do so.

The Committee determined in open session that it was appropriate to provide clarification where the parties sought it. The clarification sought was in respect of Particulars 11 and 12.

Particulars 11 and 12

The Registrant has admitted that [redacted] Clinic produced pro forma reports in respect of the pupils tested. The "Outcome/Results" section of the report commenced with an entry to report "Vision Good/ Eyes Healthy". There was provision for marking either a "yes" box or a "no" box.

Particular 11 is based on the fact that the "yes" box had been marked in respect of six pupils when the clinical records stated that that it had not been possible to measure visual acuity.

Although the Registrant accepts that it was misleading to state that vision was good he submits that it was not misleading to state that the eyes were healthy. To that extent, although Particular 12 was admitted, this was limited to an admission that it was misleading to state that vision was good.

Accordingly, the Committee was asked to decide whether it was also misleading to state that the eyes were healthy.

The Committee had regard to all of the evidence including the documentary evidence and the evidence of Mr Booth and the Registrant. Mr Booth provided a Supplementary Report in which he stated that "A retina may look healthy but without an assessment of visual function it cannot be stated that it is healthy. In my opinion both a measurement of visual function and an examination of the eyes are required before a reasonably competent optometrist can state that the patient's eyes are healthy."

The Registrant's position is that in the absence of a visual acuity test there is nothing wrong in reporting that the eyes are healthy. It was suggested to Mr Booth that on many occasions an assessment on the health of the eye is based on "so far as I can tell".

The Committee preferred the Council's position to that of the Registrant. The recipients of the letters received an outcome letter which contained an unqualified report both that the child's vision was good and that the eyes were healthy. If the assessment of

healthy eyes was only based upon a tentative view, it would have been open for the Registrant to have explained the limited nature of his assessment. In the absence of any qualification to that assessment, the recipient would be left with a false impression. It was not possible to report vision and health separately because there was only one box covering both aspects.

Accordingly, the Committee found Particular 12 proved in its entirety.

Misconduct

The Committee has heard submissions on behalf of the Council and the Registrant.

Mr Corrie invited the Committee to find that there had been misconduct in respect of the Particulars found proved.

The Committee was reminded that it was a matter for its professional judgement to determine that there had or had not been misconduct. It was open for the Committee to determine that there had not been misconduct even in relation to findings of dishonesty.

The Committee heard and accepted the advice of the Legal Adviser who referred to the case of Roylance v GMC (No2) [2000] 1 AC 311 and suggested that the appropriate test for the Committee to use was to consider whether there had been a serious departure from the standards expected of a reasonably competent registrant.

The Committee had regard to the Code of Conduct (the Code) applicable at the time and took into account the evidence of Mr Booth.

The Committee accepted that not every breach of the Code would result in a finding of misconduct. It would have to be satisfied that the departure from the Code was serious enough to warrant a finding of misconduct.

The issue of whether or not there had been misconduct was a matter for the Committee alone to determine and it reached its decision independently of any view expressed in the expert reports.

Particular 1

Although the Registrant has admitted to carrying out around 210 sight tests without authorisation by NHS England, the Committee has accepted his explanation. Mr [redacted] confirmed that he had told the Registrant effectively that it would be permissible for him to carry out tests in schools so long as he did not charge the domiciliary fee. The Registrant was told that he did not have to notify the NHS prior to conducting sight tests. Although there was a blanket restriction on him conducting NHS sight tests in schools he was not made aware of this by the NHS – in fact he received advice that he could claim for school visits.

In the circumstances, the Registrant's behaviour, in respect of this Particular, could not be described as misconduct. His conduct was as a result of advice he received from his regular NHS contact.

Particular 2

In this Particular the Registrant has admitted to carrying out around 416 sight tests.

These circumstances are similar to those of Particular 1 and accordingly there is no finding of misconduct.

Particular 3

The Committee had regard to the words of the Particular and concluded that the Registrant's actions did amount to a serious departure from the standards expected of a reasonably competent practitioner. He had solicited the carrying out of sight tests on a significant number of patients with whom he had no prior relationship. The basis upon which he offered to carry out sight tests was an unmet need to provide them to patients whose vision might otherwise not be tested.

The Registrant admitted in live evidence that he spent far less time on each sight test than he would when examining patients in his own premises. On one occasion he saw at least 166 patients in one day. It was the evidence of Mr Booth that the maximum number of sight tests that could properly be done on one day was 26. The Committee determined that the level of seriousness was increased because the Registrant was testing children in the absence of their parents and the testing occurred on more than one occasion and at more than one location.

The Committee was satisfied that the Registrant's failure to carry out adequate sight tests was far below the standards required of a reasonably competent optometrist and therefore amounted to misconduct.

Particular 4

The Registrant accepted, in live evidence, that he now knows that the tests were inadequate but that he did not know this at the time. The Committee did not accept this account and found it to be implausible. The Committee formed the view that the Registrant was well aware that he had been carrying out inadequate sight tests and was therefore aware of this when he submitted claims for payment.

The Committee determined that the facts found in Particular 4 also amounted to a serious departure from the standards expected of a reasonably competent registrant.

The Committee was satisfied, in these circumstances, that his submission of forms for payment for inadequate testing amounted to misconduct.

Particular 5(b)

The Committee then went on to consider whether or not its finding of dishonesty, in Particular 5 (b) should result in a finding of misconduct.

It accepted that a finding of dishonesty need not, of itself, bring about a finding of misconduct. The Committee had regard to the number of claims made. It took into account the number of patients the Registrant examined and contrasted that with the number of patients that he ought to have examined. It formed the view that the number of claims made was so excessive that the dishonesty involved was a serious departure from the standards expected of a reasonably competent registrant.

The Committee was therefore satisfied that the Registrant's behaviour, in Particular 5 (b) amounted to misconduct.

Particular 6

The Committee then went on to consider whether the various failures of the Registrant to obtain informed consent should result in a finding of misconduct. The Committee considered each Sub-Particular separately.

The Committee had regard to the wording of the consent letter that was sent to [redacted] parents. It considered that it was wholly inappropriate for an opt out procedure to be engaged when seeking to carry out sight tests on a child. The Committee was satisfied that there had been a serious departure from the standards expected of a reasonably competent registrant.

The Committee then had regard to the description of the procedure to be followed during testing. It formed the view that the description of the tests as "being part of a screening programme" was wholly inaccurate. There was no programme and the tests that were carried out were far more invasive than routine screening. The Committee was satisfied that there was a serious departure from the standards expected of a reasonably competent registrant.

The Committee then considered whether or not the Registrant's admission that he did not provide adequate information as to the actions and/or possible outcomes of a sight test also amounted to misconduct. The Committee had regard to all of the facts and circumstances and considered that this Sub-Particular was not sufficiently serious a matter to warrant a finding of misconduct. A parent or guardian receiving a communication would be likely to be aware of some of the outcomes of testing. The recipient of the letter would anticipate receiving more information following any adverse outcome.

Accordingly, the Committee determined that there was misconduct in respect of Sub - Particulars (a) and (b) but not (c).

Particular 7

The Committee then went on to consider similar issues with regard to [redacted] and adopted the same reasoning. The issue of an opt out process did not arise.

It determined that whilst Sub-Particular (a) amounted to misconduct, there should be no such finding in respect of Sub-Particular (b).

Particular 8

The Committee had regard to the information obtained by the Registrant and noted that there was a complete lack of essential information (as set out in Sub-Particulars (a) to (f) of Particular 8). The Registrant had obtained no information from the parents or guardians of the pupils. The system that he had in place was inadequate in that he relied on a very limited history being obtained from the children during the short period of time that they were being seen by him or his assistant. The Committee considered that his failure to ensure there was an adequate system to obtain essential information

was a serious departure from the standards expected of a reasonably competent registrant and did amount to misconduct.

Particular 9

The Committee had regard to the wording of Particular 9 and the evidence produced by the Council in respect of this Particular. It concerns poor record keeping; there was no suggestion of dishonesty. There was no precise correlation between the number of clinical records and the number of claims made.

The Committee took into account the fact that the discrepancies were significant.

In respect of the visit to [redacted] the Registrant claimed for 134 sight tests on day 1 and 74 on day 2. The corresponding clinical records only disclose 122 and 70.

Of three days claimed for [redacted] the Registrant claimed for 185 sight tests on day 1 ,145 on day 2 and 76 on day 3. The corresponding clinical records only disclose 166, 142 and 73 records.

The Committee considered that these significant discrepancies which occurred on all of the days the Registrant was testing were sufficiently serious as to amount to a finding of misconduct.

Particular 11

The Committee noted that this Particular related to the 6 patients (out of a sample of 100) listed in Schedule C. The Committee was concerned that the provision of inaccurate information was serious given the vulnerable nature of the patients. This may have been the only opportunity that the patient had to be examined by a professional. There is an obvious deadline in the treatment of some children's ocular conditions. By providing parents/ guardians with outcome letters that were not accurate the Registrant put patients at material risk.

The Committee considered the provision of this information to be a serious departure from the standards expected and amounted to misconduct.

Particular 12

In light of the findings of misconduct in respect of Particular 11 the Committee concluded that a finding of misconduct in respect of Particular 12 was inevitable.

Particular 13

The Registrant has admitted that he failed to refer 28 patients (out of a sample of 100) when it was clinically indicated that he should do so. The Committee had regard to the number of patients affected and concluded that his failure to refer 28 patients amounted to a significant departure from the standards expected of a reasonably competent registrant. A significant number of patients were put at risk of harm. Accordingly, the Committee concluded that such failure amounted to misconduct.

Particular 14

In considering the issue of misconduct the Committee had regard to the earlier part of its determination. The Registrant was under a professional duty to cooperate with the

NHS investigation and provide accurate information. As at 10 September 2015, the Registrant had sufficient time to investigate the facts. The Committee determined that he had made a number of claims that were not true. He said that the sight tests took 20 minutes (on average) and that there were 2-4 staff present. He also represented that initial contact in relation to the sight tests had been made by the respective schools.

The Committee concluded that this was a significant departure of the standards expected of a reasonably competent registrant and accordingly amounted to misconduct.

Particular 15

The Committee accepted that not all findings of dishonesty will result in a finding of misconduct. However, it concluded that the Registrant provided incorrect information to the NHS in an attempt to make the situation more favourable to him. As such there was a serious departure from the standards expected of a reasonably competent registrant which amounted to misconduct.

Code of Conduct

The following parts of the Code were identified as having been departed from:

1,5,6,7,10, 11 & 19.

THE CODE

As a registered optometrist, dispensing optician, or person undertaking training as an optometrist or dispensing optician, you must:

1. *; make the care of your patient your first and continuing concern;*
2. *;*
3. *;*
4. *;*
5. *give patients information in a way they can understand and make them aware of options available; on the issue of patient consent be aware of and comply with the guidance published by professional bodies;*
6. *maintain adequate patients' records;*
7. *respect the rights of patients to be fully involved in decisions about their care;*
8. *;*
9. *;*
10. *be honest and trustworthy;*
11. *ensure that financial and commercial practices do not compromise patient safety;*
12. *;*

13.;

14.;

15.;

16.;

17.;

18.;

19. *ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession.*

Adjournment

Following the Committee announcing its decision on Misconduct, at the end of the fifth day, Mr McGee produced further documentation, on behalf of the Registrant, and intimated that the Registrant would be providing live evidence, for the impairment stage, on the following day.

When the hearing resumed on the sixth day the Registrant was not present.

Mr McGee, on behalf of the Registrant explained that the Registrant had [redacted] overnight and sought to adjourn the case in terms of Rule 35. Having sought further instruction, on the issue of whether or not it was possible for him to participate by video link, Mr McGee informed the Committee that his client was [redacted] to give evidence. He informed the Committee that he would not have advised the Registrant to give evidence even if he was physically present in the room.

Mr Corrie did not oppose the application. He informed the Committee that he had taken instructions and the Council did not insist on the production of medical evidence.

The Committee accepted that adjournment was necessary in the interests of justice.

It directed that a transcript of the hearing should be made available in advance of the resumed hearing. It accepted submissions, made by both parties, that the hearing should be listed for a further three days.

Having consulted all parties the Committee fixed new dates for the resumed hearing as 10 to 12 June 2020 in terms of Rule 36 (2).

Resumed hearing.

The case resumed, on 10 June 2020, for determination on impairment and later stages (if any) by way of a remote hearing through video conferencing.

Additional documentary material had been provided on behalf of the Registrant. Mr McGee advised the Committee that it remained the intention of the Registrant to give oral evidence at the impairment stage.

The Registrant did so and in that evidence he adopted the contents of his letter to the Committee dated 16 March 2020. Some of the material, contained in the letter, included details of the impact that the allegations and his interim suspension had on his personal life.

In his oral evidence he explained that he remains a Director of the Practice which continues to provide NHS services under a Mandatory Contract. Following the events that formed the allegation, particularly the school visits, the Practice lost its Additional Services Contract for London. However, the Practice retained its Additional Service Contract for Essex. Despite being the subject of an interim suspension order for approximately five years he has remained involved in the day to day running of the Practice. He has served as an assistant to locums and been involved in managing the Practice including submitting claims made to the NHS which is aware of his interim suspension order. He assured the Committee that he would not be working in schools as part of his practice.

He reminded the Committee that this was the only time that he has been the subject of regulatory concern.

The Committee considered this evidence, together with all of the other evidence, including testimonials, CET statements and certificates of courses completed, when deciding the issue of impairment.

Impairment

The Committee heard submissions from Mr Corrie on behalf of the Council who invited the Committee to make a finding of impairment. He conceded, as a matter of principle, that findings of dishonesty need not result in a finding of impairment. He submitted that the misconduct found, in this case, ought to result in a finding of impairment. Mr Corrie submitted that there was impairment for four reasons. Firstly, due to lack of insight by the Registrant into his conduct. He was unable to answer why he acted in this way and showed a lack of empathy for how his conduct affected his patients and the profession. Secondly that the risk of harm was significant for the same reasons and that there was no explanation about how the Registrant would avoid this in the future. Mr Corrie submitted that the Registrant has not demonstrated that he no longer presents a risk to patients. Thirdly he submitted there was high gravity because the clinical failings were very serious relating to inadequate testing, consent issues, failure to refer, and potential harm to children. Further the findings of dishonesty were very serious Finally he submitted that if impairment was not found it would undermine public confidence in the profession.

Mr McGee on behalf of the Registrant submitted that a finding of impairment was not inevitable following the findings of dishonesty. He submitted that the Registrant's early admissions to the majority of the particulars demonstrated insight. The Registrant had attracted no regulatory concerns prior to the misconduct and none since. He reminded the Committee that the Registrant's Practice had been compliant with NHS contracts (Mandatory and Additional) for the intervening years without complaint and had been the subject of an audit in 2016. There had been no concerns arising from the audit. He drew the attention of the Committee to the references and testimonials produced by the Registrant. They spoke of him being an honest and competent practitioner who was a credit to his profession. He submitted that the Registrant's distress when giving evidence was palpable and genuine. The Registrant had produced CET Statements and certificates of completed courses demonstrating his commitment to keeping up to date and remediating the issues that led to him being before the Committee. Since the Registrant will no longer be visiting schools it was open for the Committee to conclude that the risk of repetition was minimal.

In addressing the Committee on the issue of public interest he submitted that a finding of impairment was not required. It was open for this Committee to issue a warning following a finding of no impairment.

The Committee heard and accepted the advice of the Legal Adviser. He referred, in particular, to the cases of *Cohen v GMC [2008] EWHC 581 (Admin)* and *CHRE v NMC and Grant [2011] EWHC 97(Admin*).

The Committee had careful regard to the issues identified in the oral submissions by the representatives and considered all of the evidence before it. It reminded itself that there was no burden of proof and exercised its professional judgement.

Central to the issue of remediation was the issue of whether or not the Registrant had demonstrated sufficient insight into the reasons for the misconduct. The Committee remained concerned that the Registrant was as evasive in answering difficult questions at the impairment stage as he had been at the facts stage. When asked whether his actions caused risk of harm to the patients, he merely responded by saying that his tests could have been better. He did not expressly accept there was a risk of harm.

His letter of 16 March 2020 mainly concentrated on the effect that regulatory proceedings had on him and his family. When confronted with the issue of what effect his actions had on patients and the profession his answers were vague and displayed little empathy for those affected by his misconduct.

He attempted to deflect blame from himself by suggesting that he had received the wrong advice. The Committee was concerned that the Registrant had failed to explain or take ownership of his actions. At the time of the school visits he was an experienced practitioner. He well knew that he ought not to have examined so many patients in so

short a time. Although he has undertaken CET where paediatric sight testing, record keeping, and submitting accurate claims had been discussed, this did not address his decision to conduct so many tests in such a short time. The Committee was left with no explanation for his decision to conduct so many tests in such a short time. He gave no explanation for his decision to submit them for payment despite knowing they were inadequate.

The Committee was also concerned about the answers provided by him in respect of the other finding of dishonesty. His explanation for providing misleading information to NHS England remained evasive. He suggested that there had simply been a failure, by him, to check the facts.

The Committee accepted that the distinction drawn between agreeing with the Committee on the one hand, and accepting its findings on the other, was a subtle one. The Registrant recognised that the Committee had made findings and whilst he accepted they had been made he did not agree with some of them. However he had carried out CET courses and carried on working in the Practice with a view to demonstrating remediation. Notwithstanding this the Committee was not satisfied that the Registrant had properly addressed the regulatory concerns.

In particular there has been no coherent explanation for him examining a large number of patients in such a short time. It was not enough for him to say that he would no longer visit schools. The Committee is not confident that, faced with an opportunity to cut corners, he would not repeat his behaviour. The Committee was also concerned that he did not provide a satisfactory explanation for how Particular 14 arose let alone any assurance that conduct similar to that in Particular 15 would not be repeated.

The Committee had regard to the test approved in Grant:

“Do our findings of fact in respect of misconduct….show that his/her fitness to practise is impaired in the sense that 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 Committee considered that all four limbs of the test were engaged both with regard to the past and the future.

The Committee considered that patients were put at unwarranted risk of harm in respect of a number of particulars found proved. The profession will have been brought into disrepute by his actions. Patient safety and honesty are fundamental tenets of the profession. The Registrant has breached both fundamental tenets. The Committee has made two separate findings of dishonesty.

In light of the limited insight displayed the Committee could not be confident that there had been sufficient remediation to satisfy it that there would be no repetition.

The Committee determined that the fitness of the Registrant to practise was impaired on the basis of public safety.

The Committee then considered the wider public interest. It considered whether or not a finding of impairment was required as a result of the collective need to maintain confidence in the profession, as well as declaring and upholding standards in the profession. The Committee determined that the misconduct of the Registrant required to be marked by a finding of impairment on the grounds of public interest also.

Sanction

The Committee heard submissions from Mr Corrie, on behalf of the Council, and from Mr McGee, on behalf of the Registrant.

Mr Corrie referred the Committee to the case of Kamberova v NMC [2016] EWHC 2955 (Admin) and submitted that it should have regard to the guidance issued at paragraph 40 of the decision. The Committee may take into account the duration of the existing interim suspension order when assessing proportionality.

He also referred to the case of Bolton v Law Society 1994 1 WLR 512 and submitted that one of the factors that the Committee should have regard to was that the reputation of the profession may be of greater importance than the fortunes of any individual member.

Mr Corrie provided the Committee with a list of what, the Council contended, were the aggravating and mitigating factors in this case.

Mr Corrie invited the Committee to have regard to the guidance on sanctions (ISG) issued by the Council ("Hearings and Indicative Sanctions Guidance" – December 2018 Edition). He submitted that, whilst the matter of sanction was always a matter for the Committee to determine having regard to the ISG, the issue of proportionality required them to consider the appropriate sanction in ascending order. This was to ensure that the Registrant was given the least burdensome sanction which would also meet the public interest.

Mr Corrie took the Committee through the various sanctions available in ascending order and submitted that the most appropriate sanction was erasure. He submitted that if the Committee was minded to suspend the Registrant the Kamberova principles should be considered.

Mr McGee also asked the Committee to consider the Kamberova principles and referred to the case of Akhtar v GDC [2017] EWHC 1986 (Admin) where these principles also met with the Court's approval.

He invited the Committee to consider, as a starting point, imposing conditional registration. He referred the Committee to part 33 of the ISG and submitted that the Registrant would be able to work under the remote supervision of a supervisor nominated by the Registrant and approved by the Council. That supervisor would be able to oversee his work and monitor the records of the Practice.

If the Committee were not minded to impose conditional registration then a similar result may be achieved by suspending the Registrant. The Registrant would be able to voluntarily work on his remediation and insight and a reviewing Committee may be told of his progress.

He drew the attention of the Committee to the terms of the Additional Services Contract between the Practice and Tower Hamlets Primary Care Trust. He submitted that this was an example of the remaining contractual arrangements between the Practice and the NHS. He referred to the provisions which entitled the NHS to terminate the Contracts if certain events occurred. The Registrant had a reasonable apprehension that the Practice would lose its contracts if a final order of suspension or erasure were to be imposed. He referred the Committee to the termination provisions contained in clause 159 of the document. Whilst it may be possible to avoid termination by replacing the Registrant as a Director he submitted that the NHS would likely have to be satisfied with the suitability of the replacement.

Mr McGee submitted that this was a factor that the Committee should consider in determining sanction as part of the tension between the rights of the Registrant and the Bolton principles.

Mr Corrie pointed out that it was unfortunate that the issue of contractual provisions was not raised in evidence.

The Committee accepted the advice of the Legal Adviser. He referred to the cases of Kamberova and Akhtar as well as the case of Lusinga v NMC [2017] EWHC 1458 (Admin). The Committee should assess the nature of the dishonesty. He also referred to PSA v HCPC & Doree [2017] EWCA (Civ) 319 with regard to the approach that a committee should take to ISG.

The Committee considered the aggravating and mitigating factors.

The Committee considered the following factors to be aggravating;

- His misconduct was serious and put a large number of vulnerable patients at risk.
- His misconduct involved dishonesty and he knowingly cut corners.
- His actions involved abuse of a position of trust.
- Although the events took place almost five years ago, he has displayed limited insight.
- He was an experienced Optometrist and knew how to perform adequate sight tests.
- The departure from the code of conduct was very serious.

The Committee considered the following factors to be mitigating:

- He has attracted no other regulatory concerns during his relatively long career.
- He admitted some of the allegations.
- There is no evidence of actual harm.

The Committee considered the sanctions available to it from the least restrictive to the most severe.

The Committee first considered whether it would be justified in taking no action. These were not exceptional circumstances which were envisaged in the Guidance (31.2) Taking no further action would not protect the public nor would it be in the public interest. Such an order would be inconsistent with the earlier determination of the Committee.

The Committee next considered the issue of financial penalty orders. It had not been addressed on this issue and formed the view that it was not appropriate to impose one. It had regard to Part 32.4 of the ISG. This was not a situation where a penalty order was more appropriate. The Registrant obtained no financial gain as the NHS did not pay the invoices that he submitted. It concluded that imposing such an order instead of erasure, suspension or conditional registration was not appropriate, would not protect the public or address the wider public interest.

The Committee then had regard to whether or not conditional registration was an appropriate sanction. It took into account Part 33.9 of the ISG and considered whether any of the factors had been engaged. The Committee considered that the Registrant could have taken steps to obtain the help of a supervisor or mentor during his period of suspension. It was also concerned that the Registrant has still been unable to offer a satisfactory explanation for his misconduct despite the passage of time. The Committee regarded this as being attributable to a harmful deep-seated attitudinal

problem. The Registrant was a highly experienced practitioner whose skills have been praised in references and testimonials. His behaviour could not be attributable to inexperience or any other reason. The misconduct of the Registrant was not of a nature that conditions could be devised for.

The Committee then considered whether or not it should impose the sanction of suspension. It had regard to the ISG (34.1) and concluded that the misconduct was serious and could not be categorised as a "serious instance". In addition, the Committee was concerned over the limited insight developed over the past years into his serious misconduct. The Committee has already determined that there was a deep-seated attitudinal problem. Although suspension would protect the public, as the Registrant would not be practising, it would not sufficiently mark the public interest.

Having considered all other sanctions in ascending order the Committee then went on to consider erasure. It had regard to ISG (36.5) and formed the view that the Registrant's misconduct was fundamentally incompatible with him remaining on the register. The Committee first considered how serious the departure from the standards expected of Registrant this was.

The Committee had regard to the legal advice regarding the case of Lusinga. It formed the view that whilst the dishonesty involved was not at the top of the scale it was very close to it. The Practice had approached schools on the false basis that it was conducting tests as part of a "national school campaign". The Registrant has admitted that the consent letter sent to parents at both schools made reference to a "screening programme". There is no evidence of the existence of such a campaign/ programme. He went on to test hundreds of children in an inadequate way, having little regard for the impact of his actions on his vulnerable patients. The Committee considered that the means by which the Registrant dealt with such a significant volume of patients over such a short period was even more serious than the dishonest submission of claim forms. His claim for 626 tests obviously involved a complete disregard for his professional duties to conduct full tests. His claim for remuneration was extravagant and he misrepresented the basis upon which he went into schools when asked about it by the NHS, in an attempt to make his situation seem less bad.

Having concluded that there had been serious misconduct the Committee went on to consider whether or not any other factors in ISG (36.5) were engaged. It considered that his misconduct involved him abusing a position of trust with both the schools and their pupils. It also involved dishonesty. Despite the passage of time the Registrant remains unable to explain his actions.

In making its determination the Committee had regard to the guidance issued in the case of Kamberova. This was not a case where the Committee considered that it could apply any discount to the sanction it imposed in order to take into account the period spent on interim suspension.

The Committee also had regard to the contractual material and noted that the Registrant may have to relinquish his Directorship or else risk the Practice losing the NHS contracts. Whilst it accepted that the loss of his profession is bound to cause financial hardship to the Registrant, the Committee was of the view that the public

protection and public interest issues identified in the case outweighed the interests of the Registrant.

Accordingly, the Committee directed that the Registrar remove the Registrant's name from the appropriate Register in terms of Section 13F (3)(a) of the Opticians Act 1989.

Immediate order

The Committee has heard submissions from Mr Corrie on behalf of the Council who applied for an Immediate Order. Mr McGee on behalf the Registrant indicated that there was nothing that he could usefully add. The Committee accepted the advice of the Legal Adviser.

The Committee has decided to impose an immediate suspension order for the following reasons. It determined that such an order was necessary for the protections of the public and was otherwise in the public interest. To not impose such an order would be inconsistent with its earlier determination on sanction.

Revocation of interim order

The Committee hereby revokes the interim order for suspension that was imposed on the Registrant.

Chair of the Committee: Mr Graham White

Signature ……*Graham White*…… **Date: 12 June 2020**

Registrant: Mr Arif Chanawala

Signature Registrant present and received **Date: 12 June 2020**

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 note the GOC is not able to remove an alert at your request, see next question for further information.

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 alert system.