General Optical Council

BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(24)37

AND

GURMIT BANSAL (D-17181)

DETERMINATION OF A SUBSTANTIVE HEARING
20-26 February 2025

Committee Members:	Jayne Wheat (Chair/Lay) Nicola Enston (Lay) Carolyn Tetlow (Lay) Claire Anstee (Dispensing Optician) Leigh Nelson (Dispensing Optician)
Legal adviser:	Charlotte Mitchell-Dunn
GOC Presenting Officer:	Mark Millin
Registrant present/represented:	Yes and represented
Registrant representative:	John Graham
Hearings Officer:	Natasha Bance
Facts found proved:	1, 2
Facts not found proved:	N/A
Misconduct:	Found
Impairment:	Impaired
Sanction:	12 months suspension with review
Immediate order:	No immediate order

Allegation

The Council alleges that you, Gurmit Bansal (D-17181), a registered dispensing optician:

1. On one or more occasion, between February 2018 and February 2022, you supplied the patients listed in Schedule A with spectacles with a lower value and/or inferior to the spectacles the patients had originally paid for; and/or

2. Your conduct as set out at 1 above was inappropriate and/or dishonest in that you knew the spectacles provided to the patients were of a cheaper and/or inferior quality to what they paid for and/or you did not refund the patients with the difference in price.

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

Preliminary matters

Committee Member declaration

1. At the outset of the hearing, Ms Tetlow, a lay Committee Member declared that she had in the past been a patient at one of the Specsavers practices where the Registrant had worked for a few months after he left Leightons. She had ceased to be a patient there by the time the Registrant worked there and was no longer a patient at that practice. She stated that she had had no involvement with the Registrant.

2. The General Optical Council ("the Council") and the Registrant's representative confirmed that they had no issue with Ms Tetlow sitting as a lay Committee Member, and neither party requested that she recused herself due to her declaration.

3. The Committee accepted the Legal Assessor's advice, which made references to the authorities of Locabail (UK) Ltd v Bayfield Properties [2000] IRLR 96, Porter v Magill [2001] UKHL 67 and Suleman v General Optical Council [2023] EWHC 2110 (Admin).

4. The Committee bar Ms Tetlow had regard to all of the circumstances and the nature of Ms Tetlow's declaration. The Committee determined that Ms Tetlow had no personal or pecuniary interest in the case. The Committee considered that a fair-minded observer, having considered the relevant facts, would not conclude that there was a real possibility of conscious or subconscious bias.

On this basis and noting that none of the parties raised any objections to Ms Tetlow sitting as a lay Committee member, the Committee concluded that Ms Tetlow should continue to sit on the case.

Public/ Private hearing

5. At the start of the hearing, the Registrant's representative Mr Graham applied to the Committee for it to sit in private for any parts of the hearing that related to the Registrant's [redacted].

6. Mr Millin on behalf of the Council did not oppose this application. He acknowledged that matters relating to the Registrant's [redacted] must be heard in private.

7. The Legal Adviser referred the Committee to Rule 25 of the General Optical Council (Fitness to Practise) Rules Order of Council 2013 (as amended) ("the Rules"). She advised the Committee that matters relating to the Registrant's [redacted] must be conducted in private.

8. The Committee acknowledged the requirement to sit in private to hear matters relating to the Registrant's [redacted]. The Committee determined that it would sit in private in respect of any matters relating to the Registrant's [redacted].

Admissions in relation to the particulars of the Allegation

9. The Registrant admitted particulars 1 and 2 of the Allegation at the outset of the hearing. The Chair of the Committee announced those parts of the allegation proved by reason of the Registrant's admissions, in accordance with Rule 46(6).

Background

10. At the relevant time, Mr. Bansal (the Registrant) was a director at the Leightons franchise company, [redacted].

11. On 25 January 2022, a "whistleblower" raised a concern by reporting discrepancies in that the spectacle lenses and coatings being supplied to patients did not match those that had been ordered and paid for by the patient at Leightons in [redacted]. It was alleged that patients were receiving spectacle lenses of a type, design, material and/or coating, which was of lower quality and price than that for which they had paid.

12. Leightons completed an initial investigation and met with the Registrant on 4 February 2022, during which he admitted some patient orders that were supplied did not match the product dispensed and paid for by the patient.

13. The GOC have supplied evidence in respect of 327 patients. It is the GOC's case that none of the discrepancies in supply could potentially cause a clinical issue.

14. The Leightons franchise was terminated with immediate effect and the matter was reported to the Council on 17 February 2022.

Misconduct

15. On the basis that the Registrant had admitted all of the facts, the Council did not call any witnesses to give oral evidence but instead relied on the documentary evidence in the bundle. The Council opened the case, and the Committee heard submissions from both the Council and the Registrant's representative in respect of Misconduct.

16. Mr Millin on behalf of the Council addressed the Committee in respect of the case law relating to misconduct. He referred the committee to the skeleton argument produced on behalf of the Registrant and drew the Committee's attention to the following cases: Meadow v General Medical Council [2007] 1 All ER 1, Shaw v General Osteopathic Council [2015] EWHC 2721 (Admin), Remedy UK Ltd v General Medical Council [2010] EWHC 1245 (Admin) and Roylance v General Medical Council (No.2) [2000] 1 A.C. 311.

17. Mr Millin submitted on behalf of the Council that there was a degree of planning in respect of the Registrant's conduct, and it was difficult for the patients involved to realise what actually happened. Mr Millin stated the patients were overcharged. Mr Millin stated some 327 patients were overcharged and these were the only the records that the Council received. He noted that Leightons had stated within their correspondence that reimbursements had been paid to 465 patients out of a large number affected over a long period.

18. Mr Millin referred to the case of Forz Khan v Bar Standards Board [2018] EWHC 2184 (Admin) and submitted that the conduct of the Registrant was "seriously reprehensible".

19. Mr Millin submitted that the conduct was not a "one-off". He submitted the conduct occurred in respect of a large number of patients over a significant period of time. He stated that this was not a case in which the Registrant "came to his senses" and decided what he was doing was wrong. He stated the actions of the Registrant continued until he was compelled to stop because it was reported to Leightons and investigated. Mr Millin submitted in all the circumstances the conduct was serious and amounted to misconduct.

20. Mr Millin was asked by the Committee which of the Standards of Practice for Optometrists and Dispensing Opticians were engaged, and he referred the Committee to paragraph 17 of the Council's skeleton argument and set out the following standards;

    (15.) Never abuse, your professional position

    (15.2) Never abuse your professional position to exploit or unduly influence your patients or the public, whether politically, financially, sexually or by other means, which serves your own interest.

    (17). Do not damage the reputation of your profession through your conduct.

21. Mr Millin confirmed that he was not clear whether these were the codes and standards in place at the relevant time but asked the Committee to review the codes and standards in place at the relevant time.

22. Mr Millin was asked about his reference to additional patients beyond the 327 evidenced in the bundle. He confirmed that the Council brought the case on the basis of the evidence before the Committee, that is the 327 patients for which the Council had provided documentary evidence.

23. Mr Graham, on behalf of the Registrant, acknowledged that the Registrant had admitted the facts of the allegations. He referred the Committee to his skeleton argument setting out the relevant legal principles in respect of misconduct and acknowledged that the conduct was serious. He confirmed that it was appropriate that the standards applied were the relevant applicable standards at the time that the incidents occurred (2018-2022).

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

25. The Committee heard and accepted the advice of the Legal Adviser, who advised that the threshold of serious misconduct has been described in the cases of Roylance v General Medical Council (No.2) [2000] 1 A.C. 311 and Nandi v General Medical Council [2004] EWHC 2317 (Admin). The Committee was reminded that misconduct was a matter for its own independent judgement and no burden or standard of proof applied at this stage. Further, that the Committee needed to consider whether the conduct was sufficiently serious to amount to professional misconduct.

The Committee's Findings on Misconduct

26. In making its findings on misconduct, the Committee had regard to the documentary evidence it had received to date, the submissions made by the parties, the legal advice given by the Legal Adviser and the facts it had found proved by way of the Registrant's admissions.

27. The Committee considered the Council's *"Standards of Practice for Optometrists and Dispensing Opticians*" (2016 version) applicable at the relevant time.

28. The Committee considered that the following standards were engaged;

    - 15.2-Never abuse your professional position to exploit or unduly influence your patients or the public, whether politically, financially, sexually or by other means which serve your own interest;
    - 16-Be honest and trustworthy
    - 16.1-Act with honesty and integrity to maintain public trust and confidence in your profession;
    - 16.5-Be honest in your financial and commercial dealings and give patients clear information about the costs of your professional services and products before they commit to buying;
    - 17-Do not damage the reputation of your profession through your conduct;
    - 17.1-Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession.

29. In relation to all particulars of the Allegation, which had been admitted, the Committee was satisfied that there was a falling short by the Registrant of what was proper in the circumstances, with reference to the Standards set out above. However, the Committee was mindful that not every falling short of the standards is sufficient to amount to misconduct, as it must be serious. The Committee therefore went on to consider whether the Registrant's failures were serious.

30. The Committee determined that the Registrant provided patients with goods of a lesser retail value, or of an inferior quality than those which they had ordered and paid for. Patients would not easily have been able to detect the difference, if at all. The Committee found that this conduct spanned a significant period of time and occurred in respect of a very large number of patients. The Committee noted the conduct only stopped when a whistleblower intervened and as a result

of the conduct there was a significant financial gain to the practice, at patients' expense.

31. In all the circumstances the Committee considered that the conduct was seriously reprehensible, deplorable, and amounted to serious misconduct.

32. Accordingly, the Committee found that the facts admitted and found proved do amount to misconduct, which was serious.

Impairment

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

34. The Registrant gave evidence at this stage of the hearing, under affirmation, which is summarised below. The Registrant was questioned on matters relevant to impairment by Mr Graham, Mr Millin, and the Committee.

35. The Registrant confirmed that the content of the witness statement that he had provided was true to the best of his knowledge and belief. He confirmed his age and his family circumstances.

36. The Registrant confirmed that or about September 7, 1997, he partnered with his brother, a qualified dispensing optician and optometrist, to become a Leightons franchisee. They independently established a highly successful practice in [redacted], introducing the Leightons brand to this market. He stated that they had consistently delivered exceptional clinical care and customer service and earned a strong reputation within the local community. In December 2010, he stated that he assumed sole ownership and that he had continued to enhance the Leightons brand, until the termination of their agreement.

37. The Registrant was referred to his witness statement which set out that in December 2021, Mr A held informal discussions with him regarding the potential expansion of the practice into the adjacent vacant unit. Mr A provided financial projections for this expansion, which appeared promising. He also shared his own vision for the business's potential within the expanded space. Subsequently, Mr A offered a joint venture partnership to purchase a 50% share of the business. However, the Registrant declined that offer, as he was not ready to sell a portion of his business at that time. He stated within his witness statement that at this time he would have valued his business [redacted].

38. In respect of the allegations the Registrant stated within his witness statement that all the years of hard work and investment have been lost. He stated he has no [redacted] going forward. He accepted that this was his responsibility and a

consequence of his own actions but nonetheless he asked the Committee to take into account his age, as due to his age, he could not see how he would be able to recover his losses.

39. The Registrant within his witness statement explained that at a meeting with Mr A and the three directors on 4 February 2022 he was asked to explain discrepancies between the dispensed spectacle lenses and the original orders. He told them that in certain cases, to provide discounts and manage costs, he had used alternative lenses. His franchise agreement with Leightons had been terminated by Leightons. He stated he did commence separate legal proceedings against Leightons in respect of this, but several factors have precluded him from continuing these at this time, these being affordability, [redacted].

40. The Registrant stated that during the meeting with Mr A he had said he would provide a strong character reference to the GOC to help with retaining his registration. However, subsequently this reference has not been provided. The Registrant confirmed that this reference was promised due to his hard work and because it was mentioned in the meeting that there would be a GOC referral and fitness to practise process.

41. The Registrant noted that he had expressed a desire to rectify the situation at the relevant time and he had explained that it was a cost cutting exercise, he stated it was his attempt at price matching. In respect of his attitude towards compensation he confirmed he would have compensated patients had he been given the opportunity.

42. The Registrant told the Committee that he was completely devastated and at the time of the meeting his mind was “not straight”. He was asked if the situation occurred again how he would put it right and he confirmed that he would have gone through all the records of patients that had been impacted and worked in collaboration to put things right.

43. The Registrant confirmed that he had co-operated with the investigation of these matters and that looking at his behaviour he was focussing purely on costs and made the wrong choices. He confirmed if provided with the opportunity he would have refunded patients. He confirmed he would have compensated them for the lenses or given them a free pair as compensation.

44. The Registrant confirmed he was never given the opportunity to address and rectify the situation by Leightons and they did not contact him and there was no communication for them to enable him to address the matter.

45. The Registrant referred to a letter written to Leightons by his representatives at the relevant time, in respect of his termination. In the letter he confirmed that he would have preferred to stay within the business and was happy to have an open book analysis of all of the transactions in the past five years with a guarantee of the repayment of all overcharged sums to customers and with a payment to charity for those who could not be traced. The Registrant confirmed he would have assisted Leightons with analysis of the transactions and made repayment to the customers in terms of any overcharging.

46. The Registrant confirmed that he suggested that he could submit to regular audits at his own expense. The Registrant confirmed he made early admission to the allegations.

47. The Registrant was cross examined. He explained that since March 2022 he had been working as a locum. He was asked why he didn't have a reference from Specsavers, and he confirmed that this was because he had only worked there a few months. He confirmed the referees from his current place of work knew about the allegations and that this could be verified. He confirmed that he had not discussed the possibility of conditions of practice or a period of suspension with his current employer.

48. It was put to the Registrant that he did not mention dishonesty in his witness statement. He stated there was no reason for that and he had admitted the allegations. The Registrant stated this has been going through his head "a billions times" within the last three years and he could not believe that he made such a "stupid mistake". In respect of pre-planning he stated that in his head it was all about managing costs, running costs and running a practice. He stated, "that's all it was". He told the Committee there was no pre-planning or degree of planning. He stated he was running a one man show. He explained that staff costs were increasing all the time, and new people were being employed. He stated there were high costs in locum fees. He stated it was the commercials of the business, and he saw it as "just managing costs".

49. It was put to the Registrant that he must have looked at his options due to the mounting costs and noted that he had a gap to fill, and at that point devised a plan to which would result in more money coming into the business. The Registrant stated there was no planning. He stated he wasn't increasing his income; he was reducing his costs. He stated there was a plan in his head with a simple way of looking at things, but this was a "stupid mistake".

50. It was put to the Registrant that he did not stop until matters were reported. He stated that he was aware that he should not be doing this. He was asked why he didn't stop, and the Registrant stated he did not know. It was put to him that

there was no incentive to stop. The Registrant stated that there were increased costs all the time and he did something "very stupid".

51. It was put to the Registrant that patients were unknowingly and unwittingly helping to fund his business. The Registrant stated that he didn't think of it that way. He was asked if patients were ever told what had really happened and he stated he had no communication with the patients after he left the business, but he was willing to put matters right. He stated he has lost everything, but he takes responsibility for his actions. He stated he wasn't given the opportunity to put matters right.

52. It was put to the Registrant that he was trusted by patients and had damaged the reputation of the profession. He stated that he regretted that, he stated he was proud of his profession and had worked very hard and there was not a day that this matter did not go through his head.

53. It was put to the Registrant that his remediation focused on clinical matters when this was a reputational issue. He was asked how his remediation had assisted. The Registrant stated the remediation course that he has done has helped him to communicate effectively with customers and covered business ethics.

54. It was put the Registrant that he would have been aware of the codes and standards before embarking on his conduct. The Registrant stated he was aware of the standards, and he regretted what he had done.

55. The Registrant was asked questions by the Committee. He was asked how he selected the customers he overcharged and what his thought process was. He stated he wasn't able to answer that. He stated it was random and patients had been selected in no particular way, but he would make sure the lens he chose would not be detrimental to vision or in quality. He stated that they were all good quality lenses with a 50p or £1 difference and that was his thought process. He stated he didn't really know why he did it but "it was wrong".

56. The Registrant was asked if he was subject to an agreement with Leightons and bound to use certain lenses or whether he had commercial freedom. He confirmed he had 100% freedom. He was asked the rationale for down grading certain patient lenses. He stated he didn't know the specifics but generally he would look at the prescription and lens design and look at the lens to suit the purpose. He stated it would still meet the requirements. He stated he wouldn't compromise the patients' visual needs, but if the lens was "slightly cheaper he would do that".

57. The Registrant was asked to explain why he had described matters as a cost cutting exercise. The Registrant stated in the retail environment he would get patients looking for discounts and/or free eye tests, so generally this balanced out any price matching. For example, even with contact lenses he would reduce the costs. He stated he felt he would have to match with online and other competitors to ensure he obtained the business. The Registrant was asked again about whether he would have continued or stopped his conduct, and whether he wished to elaborate on this. The Registrant stated that in his conscience, his gut was telling him to stop because things were not right. He stated he would have stopped.

58. The Registrant was asked about his remediation and whether he had done the training he had referred to. He confirmed he had not. He was asked whether he had undertaken any training already in terms of ethics. The Registrant stated he was still looking at business ethics courses. He stated he had come across these on LinkedIn, which he intends to enrol on.

59. He was asked whether in regard to continuing professional development (CPD) he had conducted any relevant training. He stated he will be actively pursuing all modules that come up. In terms of courses already undertaken he stated that nothing comes to mind. He noted a previous course on professionalism and accountability.

60. It was put to the Registrant that there were larger differences than 50p or £1 per patient and, having been referred to some of the patient records, he agreed this was the case.

Submissions on Impairment

61. Mr Millin, on behalf of the Council, referred the Committee to Zygmunt v GMC [2008] EWHC 2643 (Admin), Dame Janet Smith in the Fifth Shipman Inquiry Report, Meadow v General Medical Council [2006] EWCA Civ 1390 and CHRE v NMC and Grant EWHC 927 (Admin).

62. Mr Millin noted that it was agreed by the Council that that there had been no clinical deficiencies. He agreed that to some extent there had been remediation. He noted that the reimbursement of patients had been made by Leightons and not the Registrant. Mr Millin submitted that the risk of repetition was a matter for the Committee. He acknowledged that the Registrant made early admissions and had engaged fully with the proceedings.

63. Mr Millin submitted that there must have been some planning in this case and that planning must have occurred for the Registrant to have found himself in the current situation.

64. Mr Millin made reference to the case of Bolton v The Law Society [1994] 1 WLR and noted that mitigation counted for significantly less in dishonesty cases, in contrast to cases relating to other contexts because of the need to uphold and maintain public confidence in the profession.

65. In respect of the criteria set by Dame Janet Smith in her Fifth Shipman Report Mr Millin submitted that the Registrant has in the past brought the profession into disrepute; has in the past breached one of the fundamental tenets of the profession; and has in the past acted dishonestly (*Grant* limbs (b)-(d)).

66. Mr Millin referred the Committee to the Hearings and Indicative Sanctions Guidance (HISG). He submitted that the Committee was entitled to conclude that the Registrant's fitness to practise is currently impaired.

67. Mr Millin submitted that a finding of impairment must be made in this case in order to maintain public confidence in both the profession and also in the regulatory process.

68. Mr Graham on behalf of the Registrant relied upon his skeleton argument, which set out the following in respect of impairment;

> "*It is generally recognised that the principle purpose of a Fitness to Practise Panel is the preservation and maintenance of public confidence in the profession rather than the administration of retributive justice.*
>
> *Therefore, some of the relevant factors the Committee may wish to consider in this case with the determination or otherwise in order to assist with impairment are..:*

- *Is the misconduct remediable?*

The GOC has presented their case on the basis that there has been no clinical deficiencies and therefore in that regard, remediation is more likely to be achieved than would be the case in respect of clinical deficiencies.

- *Has it been remedied?*

There has been no repetition. The registrant works collaboratively in his work setting. The registrant recognises the importance of systems and processes and the importance of putting the patient first at all times.

- *The risk of repetition*

We would humbly submit that the risk is zero. There has been no repetition. There has been insight. There has been admissions. There has been a desire to demonstrate a positive contribution in the work setting and rebuild a career.

● Are there deep-seated attitudinal problems which render the misconduct irremediable?

Based upon the registrant's subsequent conduct we would submit there are no attitudinal concerns.

● Where (sic) the conduct has been remedied is a matter for the Committee.

● Has the Registrant shown sufficient insight as to what he did was wrong and how to avoid repetition in the future?

When first interviewed in February 2022, the registrant made appropriate admissions. He has made admissions to the investigation team. He has engaged with the process. He has made admissions in these proceedings. He has sought to learn from his mistakes and demonstrate that he is and can be an asset to the profession.

● Is the Registrant liable to put any patient at risk?

This is a case in which the GOC present. There are no clinical deficiencies.

● Has the Registrant engaged with the proceedings?

The registrant has been fully cooperative with the process. Responded when necessary. And engaged fully with the proceedings.

● How did the Registrant present when providing evidence.

● Has the Registrant co-operated with the process?

The registrant has fully engaged with the process. As well as making himself available in terms of presenting evidence.

In light of the Registrant's Witness Statement together with the testimonials, the appropriate and cogent evidence is now before the Committee in terms of the appropriate reflection insight and remediation.

Therefore in terms of the above matters in so far as they are appropriate and relevant we would invite the Committee to consider and give appropriate weight and credit to the Registrant in terms of the following, this evidence is both relevant at stages 2 and stages 3:

● The Registrant is able to produce a highly positive work testimonial from his existing employer and former colleagues. In particular we refer to the following:

1. AB (former colleague);

2. HSS (existing employer);

3. JM (former colleague);

4. RH (former employer); and

5. HH (former and current colleague).

● The references attest to the Registrant's professionalism, appropriate professional conduct with patients and colleagues, effective practice.

● The reference supplied by his existing employer and colleagues indicates a high standard of work in all areas and there are no issues with trust and indeed the opposite is the case, complete trust is placed in the Registrant.

● The Registrant's employers and colleagues have clearly valued the Registrant highly and he is an asset to the profession.

● The Registrant has demonstrated sufficient and appropriate remediation. In particular, there has been no repeat of the incidents and whilst waiting a determination, sought to improve his knowledge of professional boundaries and in particular, so as to eradicate any future risk of something like this happening again, and in particular to ensure he is not put in a position where there is a risk of such allegations and/or findings arising again..

● The Registrant should be considered as someone with a very low risk of repetition or indeed zero risk.

● The Registrant is therefore unlikely now and in the future to put any patients at unwarranted risk of harm, breach any of the fundamental tenets and/or bring the profession into disrepute in the future.

● There has been no repetition of the conduct since the actions contained (sic) of. Therefore the Registrant has remedied his conduct.

● The Registrant has engaged with the proceedings and they clearly have had a salutary effect upon him.

● He has a previous exemplary character. In particular, no fitness to practice proceedings.

● No patients were harmed as a result of his actions.

Furthermore, in light of the Registrant's detailed Witness Statement, we would suggest that the following demonstrate insight and remediation:

a. The admissions to the allegations;

b. His meticulous approach as to what safeguards are in place as part of his reflection. They include the following:

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i. Enhanced quality control and order verification;

ii. Improved communication and informed consent;

iii. Competence;

iv. Communication;

v. Learning and improvement;

vi. Auditing;

vii. Enhanced ethical training and professional development;

viii. Financial transparency and cost management;

ix. Mentorship and supervision; and

x. Patient care.

The Committee's attention is also respectfully drawn to the Council's "Hearings and Indicative Sanctions Guidance" revised edition effective date 14 December 2021. The guidance sets out that when deciding on impairment, in particular paragraph 16.

Furthermore, we would submit that if there is a finding of impairment, public safety is not engaged and if there is to be a finding we would submit that the public interest could possibly be engaged.

Subject to reading the determinations, if appropriate, we will seek leave to make such further submissions as may be relevant and of assistance to the Committee."

69. In oral submissions Mr Graham invited the Committee to consider the Registrant's early acceptance of matters and engagement in the process.

70. Mr Graham submitted that the Registrant was not a risk to the public, highlighting the nature of the charges, which did not relate to patient safety.

71. In relation to insight, Mr Graham submitted that the Registrant had demonstrated insight and had demonstrated remorse. He referred the Committee to the numerous testimonials provided on behalf of the Registrant and noted that he had been working since the incident without issue.

72. At the conclusion of the parties' submissions, the Committee requested that the Council provided the exact value that the Council was advancing as the difference between the lenses purchased by the 327 patients and the lenses supplied. The Committee noted that the documentation provided to it had not calculated or estimated this value. The Council requested additional time to

calculate this figure. Following several deadline extensions the Committee heard submissions from both the Council and the Registrant's representative.

73. It was submitted by both parties that agreement could not be reached as to the exact value of the loss to patients, however both parties accepted that the figure was between £15,000-£17,000. The Committee was asked to proceed with the case based on the approximate value difference of £15,000-£17,000.

74. The Committee considered that it was entirely unsatisfactory that the exact figure had not been provided by the Council from the outset. The Committee noted that a significant amount of time had been taken to obtain the figure and both parties had pragmatically agreed that the most efficient way forward was to determine the case based upon the approximated value. In all the circumstances, and in considering proportionality, expediency and overall fairness the Committee determined that an approximate value of £15,000-£17,000 was sufficient for the purpose of its deliberations. The Committee concluded that the discrepancy was unlikely to make a difference to its decision-making. Spending further time seeking to reach an agreed figure, which the parties submitted would be unlikely, would not be proportionate or expedient.

75. Prior to the Committee handing down its determination on impairment, the Committee requested further clarification as to the Council's and the Registrant's positions with regard to the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry and repeated in CHRE v NMC and Grant EWHC 927 (Admin). The Committee requested submissions as to whether limb (a) of the relevant test extended to financial harm, noting that it was accepted that there were no patient safety concerns in this case. The Committee asked for clarification as to whether it was the Council's position (contrary to its skeleton argument and earlier oral submissions) that the Registrant was impaired on the grounds of both public protection and public interest or solely on the grounds of public interest. The public interest comprising of the two elements of public confidence in the profession and declaring and upholding proper professional standards.

76. Mr Millin on behalf of the Council accepted that the word harm within limb (a) envisaged physical harm, he however further submitted that harm could extend to financial harm. Mr Millin accepted that in this case that there were no patient safety concerns and the case had not been brought on that basis. He stated however that it was now the position of the Council that there

should be a finding of impairment based upon both public protection and public interest.

77. Mr Graham responded to these submissions noting that the Council had not previously put their case on this basis. He submitted that harm did not extend to financial harm and submitted that the case did not involve patient safety concerns. He submitted that a finding of impairment should not be made on the grounds of public protection and reiterated his earlier submissions in respect of impairment.

78. The Committee heard and accepted the advice of the Legal Adviser who advised the Committee that the question of impairment was a matter for its independent judgement taking into account all of the evidence it has seen and heard so far. She reminded the Committee that a finding of impairment does not automatically follow a finding of misconduct and outlined the relevant considerations set out in the case of *Cohen v GMC* [2008] EWHC 581 (Admin), namely whether the conduct is remediable, whether it has been remedied, and whether it is likely to be repeated.

79. The Legal Adviser referred the Committee to the cases of CHRE v NMC and Grant EWHC 927 (Admin), Cohen v General Medical Council [2008] EWHC 581 (Admin), Cheatle v General Medical Council [2009] EWHC 645 (Admin), Zygmunt v GMC [2008] EWHC 2643 (Admin), Meadow v General Medical Council [2006] EWCA Civ 1390, Yeong v General Medical Council [2009] EWHC 1923 (Admin), *R (Hassan) v General Optical Council [2013] EWHC 1887,* General Medical Council v Dr Iheanyi Chidi Nwachuku [2017] EWHC 2085 (Admin)**.** Following the additional submissions regarding public protection, the Legal Adviser provided additional advice which included reference to paragraph 33 of the case of General Medical Council v. Armstrong [2021] EWHC 1658 (Admin).

The Committee's findings on Impairment

80. In making its findings on current impairment, the Committee had regard to the evidence it had received to date including the Registrant's oral evidence, the submissions made by the parties, the HISG, the legal advice given by the Legal Adviser and its earlier findings.

81. The Committee considered that the Registrant's misconduct had, in the past, brought the reputation of the profession into disrepute, breached fundamental tenets of the profession and been dishonest. It next considered whether the

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

82. The Committee was of the view that the misconduct which it had found proved related to conduct that was dishonest and had occurred over a period of four years and in respect of 327 patients. Given the nature of the misconduct which involved repeated dishonesty, the Committee considered that this was very difficult to remediate.

83. The Committee turned next to consider whether the Registrant's misconduct had been remedied by him since the events which took place between 2018 and 2022. The Committee noted the steps that the Registrant has taken in order to remediate, which included some reflection in his witness statement and remorse expressed in his oral evidence. The Committee also took account of the Registrant's positive testimonials.

84. The Committee acknowledged that the Registrant was precluded from taking practical steps to reimburse or compensate the patients that were affected as Leightons had terminated his contract with them and undertook that exercise themselves.

85. In respect of remediation the Committee noted that although the Registrant's witness statement made references to courses which he intended to undertake in relevant areas e.g. ethical practice, he had not yet undertaken any such training despite the length of time since his misconduct.

86. The Committee considered that there was limited information before it in respect of what remedial steps had already been taken by the Registrant to address the dishonesty in this case, for example the Registrant was unable to articulate how the CPD courses he had undertaken addressed the areas of honesty and integrity.

87. The Committee considered the level of insight demonstrated by the Registrant, in his written statement and his oral evidence. The Committee considered that while the Registrant has acknowledged his mistakes, shown genuine remorse and made early admissions, he has demonstrated only limited insight into his dishonesty. For example, the Committee noted that the Registrant was unable to comment in any specific detail on the rationale behind his dishonesty and focused on criticising the actions of Leightons after their investigation. The Committee considered that the Registrant did not adequately address the impact of his actions on patients and the profession as a whole.

88. Overall, the Committee found that the Registrant had not fully addressed his misconduct and has not fully remediated.

89. The Committee turned next to consider the likelihood of repetition. The Committee had regard to testimonials provided by existing and former employers and colleagues, which contained positive comments as to the Registrant's integrity. The Committee noted that a number of years have passed since the misconduct occurred, and there had been no further concerns raised. However, the Committee considered that the Registrant had not held a similar position akin to being the owner of a business.

90. The Committee considered its previous conclusions that the Registrant had not developed full insight or completed adequate remediation. The Committee therefore concluded there still remains a risk of repetition in respect of the past misconduct.

91. Having determined that there remains a risk of repetition of dishonest conduct, the Committee went on to consider whether or not the Registrant's fitness to practise was impaired on the grounds of public protection.

92. The Committee was satisfied that, in the circumstances of this case, the Registrant's clinical skills were not of concern and that patients had not been put at risk of physical harm by his misconduct. The Committee considered limb (a) of the test endorsed in *Grant,* namely whether or not patients had been in the past or were liable in the future to be put at unwarranted risk of harm, and whether that test was intended to cover, for example, future financial loss.

93. The Committee took into account the GOC's overarching objective:

> *"To protect, promote and maintain the health, safety and well-being of the public, the protection of the public by promoting and maintaining public confidence in the profession and promoting and maintaining proper professional standards and conduct"*

94. The Committee concluded that the seriousness of the Registrant's dishonest conduct lay in his having breached the trust patients had placed in him. It considered that the health, safety and well-being of patients did not require a finding of impairment on the grounds that patients required protection from future financial loss. Therefore, the Committee did not make a finding of impairment on public protection grounds.

95. The Committee next had regard to public interest considerations and gave further consideration to the case of *Grant*, particularly the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry repeated in that case. The Committee has already determined that limbs (b)-(d) of this test are engaged in this case, namely that the conduct had brought the

profession into disrepute, had breached a fundamental tenet of the profession and was dishonest. The Committee considered that these limbs of the test were engaged on the Registrant's past conduct in relation to the misconduct found proved, and on the basis of being '*liable in the future to so act*' in respect of the dishonesty, given that the Committee had found that there remains a risk of repetition in relation to that misconduct.

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

97. The Committee considered the extent and seriousness of the Registrant's dishonesty. The Committee noted that the dishonesty occurred over a significant period of time and involved a very large number of patients. The dishonesty was conducted for the purpose of financial gain. The Committee's view was that the dishonesty in this case was serious and systematic, involving multiple patients, and was in breach of several standards. It also involved a significant disregard for patient trust.

98. The Committee was of the view that given the seriousness of the dishonesty, the public would be very concerned and public confidence in the profession would consequently be undermined, if a finding of impairment was not made. The Committee determined that it was necessary to make a finding of impairment in this case in order to maintain confidence in the profession and in order to uphold proper professional standards.

99. Accordingly, the Committee found that the Registrant's fitness to practise as a Dispensing Optician is currently impaired on public interest grounds.

Submissions on Sanction

100. The Committee next went on to consider what would be the appropriate and proportionate sanction, if any, to impose in this case.

101. The Registrant gave evidence under affirmation. The Registrant confirmed that he was a family man with [redacted] children. He stated he was very remorseful and asked for forgiveness. He stated his profession was his life and passion. In respect of the financial impact of a sanction, he stated it would have a major impact on his family life [redacted] with other family responsibilities.

102. The Registrant stated he loves his profession, and he had done good things for his patients. He acknowledged his behaviour was a big mistake and stated he did not mean to discredit the reputation of the profession. The Registrant confirmed that he had a [redacted]. [redacted].

103. The Registrant confirmed that he had spoken to his current employer over the weekend, and he had said he would try and assist him with working going forward. The Registrant was asked about the courses he had identified in respect of business ethics on LinkedIn. He confirmed that this was something he could do within days. He confirmed the course could be done anytime online and he could complete it immediately. In respect of the course content, he confirmed that he believed it addressed running a business “correctly and honestly”. It covered what was involved in “carrying out business and dealing with customers”. The Registrant further confirmed that he was planning to attend the 100% Optical Show, and this was booked into his diary prior to the hearing. He stated he believed the content of one of the courses he intended to attend would make his understanding of the breaches clearer and included “how not to get struck off”.

104. The Registrant stated that the misconduct was not going to be repeated. He stated that he was actively researching courses to address the breaches and that he will approach the Association of British Dispensing Opticians to identify relevant courses. He stated he was prepared to attend any relevant recommended courses and put in place steps to ensure that the misconduct is never repeated.

105. The Registrant confirmed that from March 2022, he has worked as a Dispensing Optician. He stated he worked at Specsavers for a few weeks and then went to the [redacted] and then Specsavers in [redacted]. He confirmed that he has been working at Specsavers [redacted] since April 2022 and there have been no similar incidents. He stated that he has worked for his current employer for over three years, and they wouldn’t have employed him if they thought he was a danger or dishonest. He confirmed his employer had provided written character references.

106. The Registrant was asked a question by Mr Millin on behalf of the Council. He was asked why he had not taken the LinkedIn course despite it being available at any time online. The Registrant confirmed that he was very [redacted], his “head had not been in the right place” and that the proceedings had been “overhanging him”. He stated he wanted to get through these proceedings and know where he stood before he started to address the breaches and discussed his future. The Registrant was asked about his future with his current employer. He confirmed that there was no confirmation as to whether he would have a job, but the possibility had not been ruled out.

107. The Committee heard submissions from Mr Millin on behalf of the Council. He confirmed that he had no instructions on behalf of the GOC to urge for any

particular sanction. He confirmed that he wished to make observations on the Committee's findings and the applicable law.

108. Mr Millin confirmed the Committee's findings in respect of misconduct and noted that the Committee had found dishonest conduct over a period of four years in respect of the 327 identified patients in Schedule A. Mr Millin confirmed the Committee's findings in relation to the Registrant's insight and noted that the Committee had observed that the Registrant had not held a similar position akin to being the owner of a business.

109. Mr Millin referred the Committee to paragraph 21.2 of the HISG. He submitted that the purpose of a sanction is to protect patients and the wider public. Mr Millin drew the Committee's attention to the specific guidance within the HISG on dishonesty and noted (paragraph 22.4) that there was no blanket rule or presumption that erasure is the appropriate sanction in all cases of dishonesty although a failure to impose any sanction for dishonesty may be found to be unreasonable in light of the importance of maintaining public confidence in the profession.

110. Mr Millin noted that the Committee would need to consider the extent of the dishonesty and its impact on the Registrant's character, the wider reputation of the profession and public perception of the profession overall. Mr Millin referred to the case of *Bolton,* he stated that whilst it was an older authority it was still good law. He submitted that the authority emphasised that the reputation of the profession was more important than the fortunes of any individual member.

111. Mr Millin emphasised the importance of the public perception and maintaining proper standards and public confidence in the profession. Mr Millin confirmed that the Committee should considered the least restrictive sanction first. He noted that taking no further action, imposing a financial penalty or Conditions were unlikely to be proportionate given the Committee's finding of dishonesty and its duration.

112. Mr Graham addressed the Committee on behalf of the Registrant. He submitted that the authority of *Bolton,* was old and related to the solicitor's profession and there had been a cautious approach adopted by the courts in respect of seeking to apply principles in one profession to a completely different profession.

113. Mr Graham submitted that the Committee should have regard for the principle of proportionality and weigh the interests of the public against those of the Registrant. Mr Graham submitted that the GOC had not advanced any positive submissions in respect of any particular sanction and had not stated that they were asking for erasure in this case.

114. Mr Graham noted that the Registrant had been practising without issue since March 2022. He submitted the Registrant was remorseful and had paid a high price. He had lost his business and everything he invested into it, along with his reputation. Mr Graham submitted that the Registrant had made efforts to demonstrate reflection.

115. Mr Graham submitted that just because there was a finding of dishonesty in this case, it did not follow that an otherwise competent professional should be automatically erased from the register. Mr Graham submitted that Committee should not conclude that the Registrant's conduct is fundamentally incompatible with registration.

116. Mr Graham noted that the Registrant made early and full admissions and accepted his actions. He stated he didn't seek to cover up his behaviour and has been fully cooperative throughout the proceedings. Mr Graham submitted that this was not a case in which the Registrant had demonstrated a harmful deep-seated personality issue. Mr Graham submitted that the Committee had noted that the Registrant had taken some steps to remediate which included some reflection in his written statement and remorse expressed in his oral evidence. He submitted that the Registrant has demonstrated some insight into his dishonesty and not a persistent lack of insight. Mr Graham submitted that it was possible for the Registrant to further develop his insight, and this could be demonstrated to a reviewing committee if he was subject to a suspension. In all the circumstances Mr Graham submitted a period of suspension on such terms as the Committee considered appropriate, was the most proportionate sanction.

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

The Committee's findings on Sanction

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

    1) The persistent and prolonged nature of the dishonesty which ceased only when uncovered by an investigation;

2) The abuse of his patients' trust, where they were unlikely, if at all, to have been aware that the product they received was not the product they paid for;
3) There was only limited evidence of insight and remediation;
4) The Registrant's actions were carried out for the purpose of financial gain to his business.

119. The Committee considered that the following mitigating factors were present:

1) The Registrant has demonstrated genuine remorse;
2) The Registrant made full admissions at the outset of the investigatory process by Leightons;
3) The Registrant has fully co-operated with the GOC's proceedings and made early admissions to the allegations;
4) The Registrant has no previous disciplinary issues and prior to the misconduct had a lengthy unblemished career.

120. The Committee next considered the sanctions available to it from the least restrictive to the most severe, starting with no further action. The Committee considered taking no further action as set out in paragraphs 21.3 to 21.8 of the HISG. It concluded that taking no action would not be an appropriate outcome in this case. The Committee considered that the dishonest conduct of the Registrant was towards the higher end of the scale, due the length of time that the dishonesty occurred, and number of patients and amounts involved. The Committee considered that taking no further action was not proportionate nor sufficient given the seriousness of the case and the public interest concerns. Furthermore, there were no exceptional circumstances to justify taking no action in this case.

121. The Committee considered the issue of a financial penalty order. However, it was of the view that such an order was not appropriate. The Committee considered that this sanction would not be a sufficient sanction to meet the public interest. Further, it had limited information about the financial position of the Registrant and the extent of his direct financial gain remained unclear.

122. The Committee considered the HISG in relation to the imposition of conditions. It was of the view that conditional registration would not be practicable due to the nature of the misconduct, which did not involve clinical concerns requiring supervision or retraining, which conditions often seek to address. Conditions would not sufficiently mark the serious nature of the Registrant's misconduct or

address the public interest concerns identified. The Committee concluded that conditions could not be devised to address the nature of the misconduct and which would be appropriate, proportionate, workable or measurable in this case.

123. The Committee next considered Suspension. In particular, the Committee considered the list of factors contained within paragraph 21.29, that indicate that a suspension may be appropriate, which are as follows:

Suspension (maximum 12 months)

21.29 This sanction may be appropriate when some, or all, of the following factors are apparent (this list is not exhaustive):

a. A serious instance of misconduct where a lesser sanction is not sufficient.

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

c. No evidence of repetition of behaviour since incident.

d. The Committee is satisfied the registrant has insight and does not pose a significant risk of repeating behaviour.

e. …

124. The Committee was of the view that the factors listed in a) and c) were applicable in this case. Whilst the Committee noted that the dishonesty engaged in by the Registrant demonstrated a clear attitudinal problem it did not conclude that this was an indication of a harmful deep-seated personality problem. The Committee considered that the Registrant has worked without restrictions or issues since the misconduct, albeit in an alternative capacity, and noted the Registrant's co-operation with these regulatory proceedings, his early admissions to the allegations and his genuine remorse. The Committee also took into account the testimonials from current colleagues and his employer, and who are aware of the allegations, who all consider the Registrant to be honest.

125. The Committee has determined that the Registrant's insight was limited and concluded that there remains a risk of repetition in respect of the misconduct. However, the Committee considered that there was not a "*significant risk of repeating behaviour*", given the Registrant's willingness to address his

behaviour, his expression of genuine remorse during his oral evidence and his engagement in these proceedings to date.

126. The Committee considered in all the circumstances that the most proportionate sanction would be a lengthy period of suspension that would mark the seriousness of the misconduct and afford the Registrant the opportunity to further develop his insight and show remediation.

127. The Committee still had remaining concerns with regard to the Registrant's insight and the risk of repetition especially given the seriousness of the dishonest conduct. The Committee therefore went on to test this proposition against the criteria for erasure, the most serious sanction.

128. The Committee considered the factors in relation to erasure under *Paragraph 21.35* which indicates the circumstances where this sanction may be appropriate:

a. Serious departure from the relevant professional standards as set out in the Standards of Practice for registrants and the Code of Conduct for business registrants;

b. Creating or contributing to a risk of harm to individuals (patients or otherwise) either deliberately, recklessly or through incompetence, and particularly where there is a continuing risk of harm to patients;

c. Abuse of position/trust (particularly involving vulnerable patients) or violation of the rights of patients;

d. …

e. …

f. Dishonesty (especially where persistent and covered up);

g. …

h. Persistent lack of insight into the seriousness of actions or consequences.

129. The Committee considered that some of the factors were present, namely factors a), c) and f). The Committee noted that the Registrant's conduct amounted to a serious departure from the *Standards,* was an abuse of a

position of trust and was an example of persistent dishonesty. The Committee took into consideration the fact that the Registrant did not seek to cover up his dishonesty at any stage and made early admissions. Further, there was no evidence of patient harm, no evidence of any impact on vulnerable patients or evidence of any violation of patient rights.

130. The Committee considered carefully the issue of insight and concluded, on balance, that there was not a *persistent lack of insight* from the Registrant. The Committee considered that the Registrant has demonstrated, whilst giving evidence at this stage of the proceedings, that he is now aware of the importance of showing that he understands what went wrong and demonstrating it will not be repeated. It was the Committee's view that there appears to have been some development of insight at this stage, albeit it was far from complete.

131. The Committee had regard to the section on dishonesty at paragraph 22.4 of the HISG. It noted that there was no blanket rule or presumption that erasure is the appropriate sanction in all cases of dishonesty and that it was required to balance the circumstances of the case against the effect a finding of dishonesty has on public confidence in the profession.

132. The Committee was reassured by the Registrant's engagement with this Committee, and the positive testimonials and further reflection in his oral evidence, which demonstrated that his limited insight is developing. On balance, the Committee considered that erasure would be disproportionate in this case. The Committee considered in all of the circumstances of this case that the behaviour of the Registrant was not *fundamentally incompatible with being a registered professional* in accordance with paragraph 21.35 of the HISG.

133. In considering the principle of proportionality, the Committee took into account the Registrant's interests and the importance of balancing those against the public interest. In order to ensure public confidence in the profession and uphold proper professional standards, the Committee concluded that suspension was the appropriate and proportionate sanction.

134. The Committee considered that a suspension of 12 months was necessary to mark the seriousness of the misconduct, in light of the aggravating factors identified. This would give the Registrant sufficient time to reflect on his behaviour and complete the relevant remediation. The Committee considered

that a shorter period of suspension would not be appropriate given the seriousness of the case.

135. The Committee considered that a 12 month suspension order would be sufficient to ensure public confidence in the profession and to uphold proper standards.

136. The Committee also determined that a review hearing should be held between four and six weeks prior to the expiration of this order.

137. A Reviewing Committee may be assisted by the following:

- The Registrant's engagement at the next Review Hearing;
- A reflective piece from the Registrant demonstrating the development of further insight and of his understanding of what had led to the misconduct and how this could be prevented in the future;
- Evidence of the Registrant having undertaken targeted courses relating to honesty and integrity;
- Evidence of the Registrant's maintenance of knowledge and skills;
- Further up-to-date testimonials.

Immediate order

138. Mr Millin on behalf of the Council invited the Committee to exercise its discretion to impose an immediate suspension order under Section 13I of the Opticians Act 1989. He reminded the Committee that if the Registrant appealed, the order for suspension would not come into effect for several months whilst the appeal was pending. Mr Millin stated that the Committee may consider that there are grounds to impose such an order based upon the Committee's findings of misconduct, impairment and in respect of sanction. He referred to the case of NH and General Medical Council [2016] EWHC 2348 (Admin) in respect of interim orders in the public interest.

139. Mr Graham on behalf of the Registrant submitted that an immediate order was not necessary. He highlighted that the Registrant had not been subject to an interim order and has practised unrestricted for a significant period. He submitted the Committee had decided that this was not a case involving public protection grounds and in the circumstances he submitted an order was not necessary. He highlighted that the Registrant had provided him with no

instructions to appeal the Committee's decision and he had no intention to do this.

140. The Legal Adviser drew the Committee's attention to *Paragraphs 23.1 and 23.3* of the *Guidance* and advised the Committee that it must consider whether the statutory test in section 13I of the Opticians Act 1989 is met, i.e. that the making of an order is necessary for the protection of members of the public, otherwise in the public interest or in the best interests of the Registrant.

141. The Committee accepted the legal advice and had regard to the statutory test. The Committee bore in mind that it had found that there were no public protection issues in this case, therefore it determined an order was not necessary for the protection of the public. The Committee noted that the Registrant had practised unrestricted for a significant period after the misconduct and considered the high bar for imposing an order on the grounds of public interest alone. The Committee considered that the imposition of the substantive sanction of 12 months suspension was enough to satisfy the public interest in this case. In all the circumstance of the case the Committee concluded that an immediate order was not necessary. Accordingly, the Committee refused the Council's application.

Chair of the Committee: Jayne Wheat

Signature **Date: 26 February 2025**

Registrant: Gurmit Bansal

Signature *present and received via email* **Date: 26 February 2025**

General Optical Council

FURTHER INFORMATION
Transcript
A full transcript of the hearing will be made available for purchase in due course.
Appeal
Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended).
Professional Standards Authority
This decision will be reported to the Professional Standards Authority (PSA) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. PSA may refer this case to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland as appropriate if they decide that a decision has been insufficient to protect the public and/or should not have been made, and if they consider that referral is desirable for the protection of the public. Where a registrant can appeal against a decision, the Authority has 40 days beginning with the day which is the last day in which you can appeal. Where a registrant cannot appeal against the outcome of a hearing, the Authority's appeal period is 56 days beginning with the day in which notification of the decision was served on you. PSA will notify you promptly of a decision to refer. A letter will be sent by recorded delivery to your registered address (unless PSA has been notified by the GOC of a change of address). Further information about the PSA can be obtained from its website at www.professionalstandards.org.uk or by telephone on 020 7389 8030.
Effect of orders for suspension or erasure
To practise or carry on business as an optometrist or dispensing optician, to take or use a description which implies registration or entitlement to undertake any activity which the law restricts to a registered person, may amount to a criminal offence once an entry in the register has been suspended or erased.
Contact
If you require any further information, please contact the Council's Hearings Manager at 10 Old Bailey, London, EC4M 7NG or, by telephone, on 020 7580 3898.