General Pharmaceutical Council

Fitness to Practise Committee

Principal Review Hearing

Remote videolink hearing

31 May 2023

Registrant name:	Nital Chandrakant Bhailalbhai Patel
Registration number:	2036409
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Angela Black (Chair)
	Deborah Grayson (Registrant member)
	Nalini Varma (Lay member)
Secretary:	Gemma Walters
Registrant:	Present, not represented
General Pharmaceutical Council:	Represented by Gareth Thomas, Case Presenter
Order being reviewed:	Suspension (9 months)
Fitness to practise:	Impaired
Outcome:	Suspension (9 months)

This decision is an appealable decision under our rules and will not take effect until 29 June 2023 or, if an appeal is lodged, when that appeal is concluded. However, the interim suspension set out in the decision takes effect immediately and will lapse when the decision takes effect or once any appeal is concluded.

Introduction

1. On 21 October 2020 the Fitness to Practise Committee of the General Pharmaceutical Council ("the Council"), directed that the registration of Mr Patel, a pharmacist ("the Registrant"), should be subject to the imposition of conditions for a period of 12 months pursuant to Article 54(2) of the Pharmacy Order 2010 ("the Order").

2. The Committee also directed that a review of the order of conditions should be held prior to its expiry. The Fitness to Practise Committee considered the matter again at a Principal Review Hearing on 12 November 2021 when the Committee directed that the order be varied to one of suspension for a period of 9 months pursuant to Article 54(3) of the Order. The Committee directed a review of the suspension order prior to its expiry. The matter was reviewed for a second time on 15 August 2022 when it was decided that the Registrant's fitness to practise remained impaired; that Committee directed that his registration should remain suspended for a further 9 months with a review hearing prior to the conclusion of that period.

3. This hearing of the Fitness to Practise Committee has been convened for the purpose of carrying out the third review the Registrant's fitness to practise.

Background

4. At the original hearing in 2020 the Committee found the following amended allegation proved, the Registrant having made admissions:

> "You, a registered Pharmacist, being the Superintendent Pharmacist for Targett Chemist, 172, Halfway Street, Sidcup ("the Pharmacy"):
>
> 1. On 13 February 2018, in the course of an inspection of the Pharmacy, failed to produce, when requested to do so by the General Pharmaceutical Council's ("the Council's") Inspector:

1.1. the Private Prescription record for the Pharmacy;

1.2. the Emergency Supply record for the Pharmacy;

1.3. the current CD registers for the Pharmacy.

2. On 13 February 2018 you informed the Council's Inspector that the following Pharmacy records were being kept at your home:

2.1. the Private Prescription record for the Pharmacy;

2.2. the Emergency Supply record for the Pharmacy;

2.3. the current CD registers for the Pharmacy.

3. On 13 February 2018 you informed the Council's Inspector that the current CD registers for the Pharmacy were not up to date.

4. Following the inspection of the Pharmacy on 13 February 2018 you completed an improvement action plan in which you undertook, by the end of February 2018, to ensure that:

4.1. the Private Prescription record for the Pharmacy was up to date;

4.2. the CD registers for the Pharmacy were up to date.

5. On 6 June 2018, in the course of an inspection of the Pharmacy, you failed to produce, when requested to do so by the Council's Inspector:

5.1. the Private Prescription record for the Pharmacy;

5.2. the Emergency Supply record for the Pharmacy;

5.3. the current CD registers for the Pharmacy;

5.4. the Pharmacy's standard operating procedures ("SOPs").

6. On 6 June 2018 you informed the Council's Inspector that the following Pharmacy Records were being kept at your home:

6.1 the current CD registers for the Pharmacy;

6.2 the Private Prescription record for the Pharmacy;

6.3 the Emergency Supply record for the Pharmacy.

7. On 6 June 2018 you informed the Council's Inspector that the following Pharmacy Records were not up to date:

7.1 the current CD registers for the Pharmacy relating to MST, Zomorph, Fentanyl and Concerta;

7.2 the Private Prescription record for the Pharmacy;

7.3 the Emergency Supply record for the Pharmacy.

8. On 17 July 2018, in the course of an inspection of the Pharmacy, you failed to produce, when requested to do so by the Council's Inspector the Pharmacy's SOPs.

9. [deleted when amended]

10. On 17 July 2018 the Council's Inspector identified the following errors in the Pharmacy's CD registers:

10.1 the last entry made in the CD register for MST 10mg tablets was dated 27 February 2018. The Patient Medical Record showed that MST 10mg tablets were dispensed on 17 separate occasions between 27 February 2018 and 17 July 2018;

10.2 the last entry made in the CD register for Sevredol 10mg was dated 26 April 2018. The Patient Medical Record showed that Sevredol 10mg tablets were dispensed on 29 May and 2 July 2018.

11. On 5 September 2018 you informed the Council's Inspector that the current CD registers for the Pharmacy were not up to date.

12. On 5 September 2018, a pack of nine morphine sulfate 10mg/1ml vials (a Schedule 2 Controlled Drug) was found in the Consultation Room of the Pharmacy.

13. On 5 September 2018, in the course of an inspection of the Pharmacy, you failed to produce, when requested to do so by the Council's Inspector, the CD register for morphine sulfate 10mg/1ml vials.

14. On 5 September 2018, in the course of an inspection of the Pharmacy, you informed the Council's Inspector that the CD register for morphine sulfate 10mg/1ml vials was being kept at your home.

15. On 5 September 2018 the Council's Inspector identified the following errors in the Pharmacy's CD registers:

15.1 the last entry made in the CD register for MST 10mg tablets was dated 27 February 2018. Invoices showed that orders of MST 10mg tablets had been made for delivery to the Pharmacy on 5 July 2018, 24 July 2018 and 22 August 2018 but none of these deliveries had been recorded in the CD register for MST 10mg tablets;

15.2 there was a discrepancy between the running balance recorded in the CD Register for MST 30mg tablets (180 tablets) and the number of MST 30mg tablets stored in the Pharmacy's CD cabinet (120 tablets);

15.3 the last entry in the CD register for Equasym XL 20mg tablets was dated 4 June 2018. The Patient Medical Record showed that Equasym XL 20mg tablets had been dispensed on five occasions after 4 June 2018, but none of these five instances of Equasym XL 20 mg tablets being dispensed had been recorded in the CD register;

15.4 invoices showed that orders of Equasym XL 20 mg tablets had been made for delivery to the Pharmacy on 9 June 2018, 7 July 2018 and 31 July 2018, but none of these deliveries had been recorded in the CD register for Equasym XL 20mg tablets;

15.5 there were two open CD registers for Zomorph 10mg capsules.

16. On 5 September 2018:

16.1 [deleted when amended]

16.2 the Emergency Supply records provided by you to the Council's Inspector did not record the nature of the emergency that gave rise to the emergency supply.

17. On 9 October 2019, in the course of an inspection of the Pharmacy, you failed to produce, when requested to do so by the Council's Inspector:

17.1. the Private Prescription record for the Pharmacy;

17.2. the Emergency Supply record for the Pharmacy;

17.3. the CD registers for the Pharmacy.

18. On 9 October 2019 you informed the Council's Inspector that the following Pharmacy Records were being kept at your home:

18.1. the Private Prescription record for the Pharmacy;

18.2. the Emergency Supply record for the Pharmacy;

18.3. the CD registers for the Pharmacy.

19. On 9 October 2019, in the course of an inspection of the Pharmacy, you informed the Council's Inspector that the following Pharmacy records were not up to date:

19.1. the Private Prescription record for the Pharmacy;

19.2. the Emergency Supply record for the Pharmacy;

19.3. the CD registers for the Pharmacy.

20. On 4 December 2019, in the course of an inspection of the Pharmacy, you failed to produce, when requested to do so by the Council's Inspector, the CD registers for the Pharmacy.

21. On 4 December 2019, in the course of an inspection of the Pharmacy, you informed the Council's Inspector that the CD registers for the Pharmacy were not up to date.

22. By keeping Pharmacy Records at your home as alleged in paragraphs 2, 6, 14 and 18 above, you risked breaching patient confidentiality.

By reason of the matters set out above, your fitness to practise is impaired by reason of your misconduct."

5. The background to the allegations is set out in the Council's skeleton argument which has not been disputed by the Registrant. That background is as follows.

6. On 13 February 2018, the Council conducted a routine inspection of the Pharmacy where the Registrant was the Superintendent Pharmacist. The Registrant did not produce for inspection the Private Prescription record, the Emergency Supply record, and the CD registers for the Pharmacy. He informed the Council's inspector that those records were being kept at his home and that the CD registers for the Pharmacy were not up to date.

7. Following the inspection, the Registrant was required to implement an action plan. He was to update all CD and Private Prescription entries by the end of February 2018. In April and May 2018, the Registrant said that he was still bringing the Pharmacy records up to date.

8. On 6 June 2018, the Council inspector returned to the Pharmacy with the Controlled Drugs

Liaison Officer ("CDLO") from the Metropolitan Police. The Registrant was again asked to produce Pharmacy records and to show that they were up to date, but he was unable to do so. He said that some of the records were being kept at his home.

9. On 8 June 2018, the Registrant attended a police interview at Bromley Police Station. The CDLO later informed the Council that no formal action would be taken against the Registrant.

10. In the weeks that followed, the Council's inspector sought updates from the Registrant about when he would resolve the outstanding issues and remaining actions from the action plan. On 17 July 2018, the Council's inspector revisited the Pharmacy and spoke to the Registrant. In the course of this visit, the Registrant did not produce the Pharmacy's Standard Operating Procedures ("SOPs"). The inspector found discrepancies as between the CD registers and entries in the patient medication record.

11. The Council's inspector and the CDLO revisited the Pharmacy on 5 September 2018. The Registrant informed them that current CD registers for the Pharmacy were not up to date. In the consultation room (not in the CD cabinet) the inspector and the CDLO found a pack of morphine sulfate 10mg/ml vials (a Schedule 2 Controlled Drug). This was a pack of ten with one missing. The inspector did not find a register for this medicine on the premises. The Registrant indicated that he still had this register at his home. In the course of the visit, the Council inspector found numerous errors in the CD registers.

12. On 26 October 2018, the Council's inspector sent out an updated action plan to the Registrant. The issues that remained to be addressed were in respect of pharmacy records. He returned to the Pharmacy in the company of his Council colleague, the lead inspector, on 9 October 2019. This was an unannounced inspection covering all 26 standards. The Registrant was present and indicated that a range of Pharmacy documents were at home and not up to date.

13. When asked to produce some of the records, the Registrant said that he could not. In the absence of CD registers, the Responsible Pharmacist on duty in the Pharmacy on that day (not the Registrant) said that he was writing down supplies of Controlled Drugs made. He produced a pile of prescriptions and invoices that he had kept in order that they could be entered when the registers were available.

14. The inspectors returned to the Pharmacy on 4 December 2019. The CD registers were not available. The Registrant was asked to go and get the CD registers but declined to do so. He stated that he was about 6 weeks behind in making entries on the registers. The Council's case was that, by keeping Pharmacy records at his home instead of at the Pharmacy, the Registrant risked breaching patient confidentiality.

<u>The principal hearing – 8-11 September, 19 and 21 October 2020</u>

15. The Registrant attended the principal hearing; he was not represented. He admitted the amended allegations and participated in the hearing, giving oral evidence.

16. The Committee concluded that the Registrant's conduct fell far below the standard for a pharmacy professional and that this amounted to misconduct. The Committee found the Registrant's fitness to practise was impaired because the Registrant presented an actual or potential risk to patients, had brought the profession into disrepute and had breached one of the fundamental principles of the profession by risking patient confidentiality. The Committee noted the Registrant had only started to take action "when confronted with being suspended. The Committee noted that as late as 13 January 2020 … again [an inspector] found Controlled Drugs not in the Controlled Drugs cabinet". The Committee acknowledged the existence of some insight but limited remediation. It was not satisfied the misconduct had been remedied or that it was highly unlikely to be repeated. The Committee imposed an interim order of conditions recognising the Registrant's willingness to comply and that he had started to take steps to regularise procedures at the pharmacy. It noted there was no "detailed plan for the future" but acknowledged the Registrant genuinely wanted to bring the standards of his professional practice up to what was required. The Committee acknowledged the Registrant's blameless career of thirty years.

17. The conditions imposed on the Registrant's practice required communication with the Council, employers/contractors and professional colleagues. The Registrant was required to work with a mentor on areas of his practice with the mentor providing a report to the Council. The Registrant was required to have a workplace supervisor who would report to the Council on his progress and development. The Registrant was also expected to undertake relevant training. The Registrant was not permitted to work as a Superintendent Pharmacist or a Responsible Pharmacist. He was restricted to practising for four days a week only at the Pharmacy and

required to employ a full-time pharmacist as Responsible Pharmacist.

First Review Hearing – 12 November 2021

18. The Registrant attended this hearing and gave oral evidence.

19. The Committee concluded that the Registrant's fitness to practise remained impaired because there had been a serious and significant lack of compliance with the conditions on his practice; the Registrant had given no adequate explanation for this. The Committee was particularly concerned by the Registrant's admission that he had not "troubled to look at the Order of Conditions since last December and not passed these on to his mentor, nor possibly either, his workplace supervisor". The Committee found there was "clear evidence of an underlying attitudinal issue … [and that] the Registrant had not remediated his impairment [sic]". It concluded that the order of conditions was not viable or workable; it had no confidence the Registrant would comply with them. The Committee therefore imposed an order of suspension for a period of 9 months with a review before the end of that period. It indicated the information which would be likely to assist the reviewing Committee.

Second Review Hearing – 15 August 2022

20. The Registrant attended the hearing and gave oral evidence. He also produced documentary evidence for the hearing.

21. The Committee concluded the Registrant's fitness to practise remained impaired. It found the Registrant's oral and documentary evidence was not sufficient to demonstrate remediation "by any systematic or structured reflection upon his conduct and neither had he developed any plan for ensuring that there was no repetition of the failings." The Committee went on to determine

> "The Registrant had demonstrated only limited insight at the Principal Hearing, the previous Reviewing Hearing, and at this Hearing, into the nature of the risks created impact upon patient and public safety (for example that poor controlled drug management and record-keeping can allow, or be exploited, to divert such drugs outside of legal supply and thus cause harm to those who consume them). This continuing lack of insight would

continue to undermine public confidence in the profession, and the regulator, if the Registrant was to be allowed to return to unrestricted practise."

22. That Committee concluded there remained a risk of repetition in the absence of the necessary insight and effective remediation; the Registrant's fitness to practise remained impaired on ground of public safety and the wider public interest, namely to maintain public confidence in the profession. The Committee found as follows:

> "… the Registrant's insight had not developed to any significant extent, if at all. He had not provided any of the information or reflections which the previous Committee had indicated to him would assist this Committee. Without that assistance the Committee considered that it had no basis to assurance itself that an order of conditions would be complied with. Indeed, it had every indication based on the Registrant's previous behaviour that it would not be complied with. Accordingly, the Committee concluded that nothing less than a further period of suspension could adequately protect the public and uphold public confidence in the profession.
>
> 52. The Registrant had failed to develop insight and had failed to remediate himself during the course of the present 9-month period of suspension. Therefore, it could see no justification for imposing any shorter period of suspension on this occasion. …. Noting that the Registrant had attended and engaged with the hearing today and had sought to assist the Committee, even if that assistance had fallen some considerable distance below what had been indicated to him would be helpful, the Committee determined that the necessary minimum, and therefore appropriate, period of suspension should be for a further period of 9 months."

23. The Committee directed a review should take place before the expiry of the suspension order. It indicated that the reviewing Committee was likely to be assisted by the Registrant providing "in advance of that hearing" the following:

    - detailed written reflections on his misconduct, in particular on how that misconduct has likely impacted upon the reputation of the profession in the eyes of members of the public and of fellow professionals;

- reflections on the importance of maintaining the standards of the profession of pharmacy;
- explanation as to how he has remediated that misconduct and ensured that any repetition of the misconduct is highly unlikely;
- along with any evidence to show that relevant training has been undertaken and consequential action implemented to address the concerns identified by the Committee at the Principal Hearing.

This Hearing

24. The Council has provided a bundle of documents in three parts together with a skeleton argument. The Registrant told the Committee he was not providing any documentary evidence for this review hearing. He also told the Committee he would not be giving oral evidence but would make oral submissions.

25. The Committee heard from Mr Thomas who set out the background to this hearing. In the course of his opening remarks and subsequent oral submissions Mr Thomas invited the Committee to find that the Registrant's fitness to practise remained impaired. He submitted that the Committee should direct a further period of suspension for a sufficient period to enable the Registrant to demonstrate remediation. It was further submitted for the Council that the Registrant should be put on notice that substantive orders and reviews may not continue indefinitely and that persistent failure to demonstrate insight and remediation could lead to indefinite suspension or removal of the Registrant's name from the register. The Committee was asked to consider an appropriate timetable for the Registrant to demonstrate the necessary insight. A similar point was considered by the High Court in the cases of **Annon v The Nursing and Midwifery Council** **[2017] EWHC 1879 (Admin)** and **Abbas v The Nursing and Midwifery Council** **[2019] EWHC 971 (Admin).**

26. In the Council's skeleton argument reference was made to the Council's inspection report of 29 April 2021 which indicated that all the Pharmacy's standards were met at that time (when the Pharmacy was under the management of a new Superintendent Pharmacist).

27. In his oral submissions, the Registrant indicated that he did not oppose the Council's submission that suspension of his registration should continue: he did not wish to practise

currently, at least until the Pharmacy had been issued a license to deal with CDs. He told the Committee the current SI was leaving but would be replaced shortly once the Council had approved the new appointment. He told the Committee a new system of electronic recording of CDs was being installed at the Pharmacy and all staff would be trained in its use. In response to a question by the Committee the Registrant said he had undertaken “a few courses” including one on leadership. He had also “gone through” a few guides on the Royal Pharmaceutical Society website; those related to the safe custody, storage and management of CDs. When asked why he had not provided the information suggested by the previous reviewing Committee, the Registrant said he did not want to be on the register at the moment and he “can’t give any evidence”. He did not feel able to do so until the new CD system was ”up and running”. He said a secondary, though not major, issue had been that (Redacted) and this had taken up his time. He said that once he was back on the register he would “hit the ground running”, without distractions and “concentrate on getting back into practice”. He would then, he said, have the confidence to demonstrate he was “capable of going back on the register” without issues of patient safety and performing the various duties expected of a pharmacist.

The Decision

28. This Committee has had regard to the documentary evidence before it, the Council’s skeleton argument and the submissions of the Registrant and for the Council.

29. The Committee first considered whether the Registrant’s fitness to practise remained impaired.

30. The findings of the Committees in 2020, 2021 and 2022 are this Committee’s starting point. Whether or not the Registrant remains unfit to practise is a matter of judgment for this Committee. However, in **Abrahaem v GMC [2008] EWHC 183 (Admin)**, Blake J said:

> “In my judgment, the statutory context for the rule relating to reviews must mean that the review has to consider whether all the concerns raised in the original finding of impairment through misconduct have been sufficiently addressed to the Panel’s satisfaction. In practical terms there is a persuasive burden on the practitioner at a review to demonstrate that he or she has fully acknowledged why past performance

was deficient, that through insight, application, education, supervision or other achievement has sufficiently addressed the past impairments."

31. The Registrant has been given by previous Committees a clear indication of the evidence which was required to assist this Committee with its task. He has chosen not to give oral evidence before this Committee. His position, as he made clear in his oral submissions, is that he is not yet able to adduce appropriate evidence but that he will do so once the Pharmacy has been issued a license for CDs.

32. In the absence of any evidence at all from the Registrant, on whom the persuasive burden lies, the Committee has no option but to find that he has not remediated his misconduct or developed further insight into the impact of it on patient safety and the wider public interest. Nor has he demonstrated the misconduct is highly unlikely to be repeated. To the Registrant's credit, he does not assert he is currently fit to practise.

33. The Committee therefore turned to consideration of an appropriate direction.

34. The Committee did not consider it would be appropriate to take no action in this case, particularly given the Registrant's long-standing non-compliance with both conditions and previous Committee's proposals designed to assist him. There is no meaningful engagement in this hearing despite the Registrant's attendance.

35. As was the case with previous Committees, this Committee finds that the risk to patient safety could be addressed by the imposition of conditions but the Registrant himself does not wish to return to practice and the Committee is not therefore confident that, were conditions to be imposed on his registration, he would comply with them. He did not do so when they were imposed in 2020, despite assuring the Committee in October 2020 that he would adhere to them.

36. This Committee has heard the Registrant's reasons for failing to follow the suggestions of previous Committees in preparing for reviews of his fitness to practise. It is concerned that he has effectively ignored those suggestions. This is commensurate with his having failed to comply with the conditions on his registration. The Registrant appears to be focussing on the management and running of the Pharmacy, in particular insofar as CDs are concerned.

However, the management of CDs is but one aspect of his misconduct in 2018-19. The conditions imposed on his registration in October 2020 are indicative of the wide-ranging concerns of that Committee. This Committee is concerned that the Registrant has not, even at the third review hearing, focussed thus far on his own fitness to practise. Earlier Committees have been troubled by the Registrant's chaotic approach and this concern has not been assuaged by the stance the Registrant has taken at this hearing. He has been given clear indications over the years of these proceedings as to what is required to demonstrate his fitness to practise (including in the list of conditions and the suggestions for preparation for review hearings) and yet has not used that information to structure his own involvement in these proceedings. He has not taken a systematic approach to the review of his fitness to practise. He has instead focussed on a single issue, the management of CDs, as a means of demonstrating the prospect of his fitness to practise. As must be clear from earlier determinations, that is not enough. He needs to demonstrate his own fitness to practise rather than demonstrating the Pharmacy is run appropriately by the current SI.

37. The last reviewing Committee indicated to the Registrant that this Committee was likely to be assisted by the following:

- detailed written reflections on his misconduct, in particular on how that misconduct has likely impacted upon the reputation of the profession in the eyes of members of the public and of fellow professionals;
- reflections on the importance of maintaining the standards of the profession of pharmacy;
- explanation as to how he has remediated that misconduct and ensured that any repetition of the misconduct is highly unlikely;
- along with any evidence to show that relevant training has been undertaken and consequential action implemented to address the concerns identified by the Committee at the Principal Hearing.

38. The Registrant has not provided any of these or a reasonable explanation for his failure to do so. His reasoning is flawed, for the reasons set out above. By way of example, even having focused on the prospect of a licence being issued to the Pharmacy this does not explain the failure of the Registrant to adduce evidence of relevant training.

39. For these reasons, the Committee has determined to continue the Registrant's suspension. It has elected to extend the suspension by a period of 9 months. It does not accept, on the basis of the Registrant's vague submissions, that the Pharmacy will be issued with a CD licence, and inspected by the Council in the next six months. Even if that were the case, this would not be sufficient, for the reasons set out above, to demonstrate the Registrant is, himself, fit to practise. His assertions in his submissions, even if fulfilled, are not sufficient to enable him to demonstrate he has remediated his misconduct.

40. The Committee accepts the submission for the Council that this is a situation which cannot continue indefinitely. The Registrant should be in no doubt that if he continues not to engage in a meaningful way with these proceedings, the next Committee will very likely give serious consideration to making an order for the indefinite suspension of his registration or the removal of the Registrant's name from the Register. The Committee intends that this should be a clear warning to the Registrant that he must engage meaningfully with these proceedings and consider carefully the previous determinations, taking the steps required of him to demonstrate he has fully remediated his misconduct, that he has genuine insight into the impact of that misconduct and that it is highly unlikely to be repeated. As has been said many times in the past, it is for the Registrant to do so. He needs to take a systematic approach to demonstrating he is fit to return to practise as a pharmacist.

41. In summary, the Committee has determined to impose a further period of suspension of 9 months with a review before the end of that period. Such a review will enable the Registrant to adduce documentary and oral evidence to demonstrate he is fit to return to practise as a pharmacist.

42. As before the Committee reminds the Registrant that the onus is on him to persuade the Committee that he is fit to practise. The next reviewing Committee is likely to be assisted by his producing the following in advance of the hearing (the Committee's emphasis):

- detailed written reflections on his misconduct, in particular on how that misconduct is likely to have impacted the reputation of the profession in the eyes of members of the public and fellow professionals;

- detailed written reflections on the importance of maintaining the standards of the profession of pharmacy, by reference to each relevant standard.

- detailed written explanation as to how the Registrant has remediated his misconduct, by reference to each paragraph of the Particulars of Allegation, as found proved.

- detailed written explanation of the steps the Registrant has taken, and will take in future, to ensure that repetition of the misconduct is highly unlikely to occur.

- documentary evidence, such as CPD certificates and/or website screenshots, of training and professional courses undertaken since the misconduct occurred, together with a written statement of consequential action implemented by the Registrant to address the concerns identified by the Committee at the Principal Hearing.

Interim Measures

43. Mr Thomas has applied for an interim measure to be imposed pursuant to Article 60 of the Pharmacy Order 2010.

44. The decision of this Committee is an appealable one under Article 55(3) of the Pharmacy Order 2010. There will therefore be a period of 28 days before the Committee's direction comes into effect. It will come into effect after the current period of suspension expires on 12 June 2023. Furthermore, during that 28 day period the Registrant could lodge an appeal and, if he did so, the Committee's substantive direction would not take effect until the appeal proceedings were concluded.

45. This is a case where the original Committee identified public protection concerns. This Committee has found that the misconduct has not been fully remediated and there remains a risk of repetition. It is also in the wider public interest for the order of suspension to continue: the public would be concerned if the Registrant were free to

practise without restriction given the background to this case and the course of these proceedings. It is therefore in the interests of public protection and the wider public interest for the Registrant's registration to remain suspended during the interim period before this Committee's direction comes into effect.

46. The Committee has therefore determined that the Registrant's registration remain suspended by way of interim measure from todays' date.