General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

In person

General Pharmaceutical Council, 6th floor, 2 Stratford Place, London E20 1EJ

18-19 July 2023

Registrant name:	Jodhan Singh Reehal
Registration number:	2221593
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Manuela Grayson (Chair) Steve Simbler (Registrant member) Wendy Golding (Lay member)
Committee Secretary:	Zainab Mohamad
Registrant:	Present represented by Martin Hadley, PDA
General Pharmaceutical Council:	Represented by Rebecca Vanstone, Case Presenter
Facts proved by admission:	All
Fitness to practise:	Impaired
Outcome:	Suspension, 12 months
Interim measures:	Interim suspension Order

This decision including any finding of facts, impairment and sanction is an appealable decision under *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010*. Therefore, this decision will not take effect until 17 August 2023 or, if an appeal is lodged, once that appeal has been 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. This is the written determination of the Fitness to Practise Committee at the General Pharmaceutical Council ('the Council').

2. The hearing is governed by *The Pharmacy Order 2010* ("the Order") and *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010* ("the Rules").

3. The statutory overarching objectives for these regulatory proceedings are:

    a. To protect, promote and maintain the health, safety and well-being of the public;

    b. To promote and maintain public confidence in the professions regulated by the Council; and

    c. To promote and maintain proper professional standards and conduct for members of those professions.

4. The Committee also has regard to the guidance contained in the Council's *Good decision making: Fitness to practise hearings and sanction guidance* as revised March 2017.

5. A Principal Hearing has up to three stages:

    Stage 1. Findings of Fact – the Committee determines any disputed facts.

    Stage 2. Findings of ground(s) of impairment and impairment – the Committee determines whether, on the facts as proved, a statutory ground for impairment is

established and, if so, whether the Registrant's fitness to practise is currently impaired.

Stage 3. Sanction – the Committee considers what, if any, sanction should be applied if the Registrant's fitness to practise is found to be impaired.

Service of Notice of Hearing

6. The Committee has seen a letter dated 26 June 2023 from the Council headed 'Notice of Hearing' addressed to the Registrant. The Committee was satisfied that there had been good service of the Notice in accordance with Rules 3 and 17.

Application to amend the Particulars of Allegation

7. The Committee heard an application from Ms Vanstone on behalf of the Council under Rule 41 to amend the Allegation so as to correct typographical errors including in relation to numbering and to the spelling of Witness 5.

8. Ms Vanstone submitted that the amendments were simply to correct obvious errors within the allegations and could be made without injustice to the Registrant.

9. Mr Hadley on behalf of the Registrant agreed with the proposed amendments.

10. The Committee was of the view that the proposed amendments were purely administrative in that they were intended to make corrections to numbering and other typographical errors which were in the original Allegation. The Committee took into account that the Registrant did not oppose the Council's application. It considered that there would be no unfairness caused to either party by the proposed amendments and it therefore agreed to amend the Allegation as proposed by the Council.

Particulars of Allegation (as amended)

"You, a registered pharmacist, whilst working as a locum pharmacist for Jardines Pharmacy, Lakeside, Shirwell Crescent, Furzton, Milton Keynes, Buckinghamshire, MK4 1GA;

1) On or around 5 September 2019 you supplied the following medications to Patient A when you did not have a valid prescription to supply them:

    a) Co-codamol;
    b) Adizem;
    c) Losartan;
    d) Warfarin.

2) You dispensed medications listed in allegation 1 above, without making a record of the supply on to Patient A's patient medication record.

3) You reprinted previously dispensed prescription labels of the medications listed in allegation 1 above and cut off the bottom of the labels containing Jardines Pharmacy details.

4) Your actions at 1 above was dishonest in that:

    a) Patient A was led to believe that the medicines at 1 above had been prescribed by their GP

5) Your actions at 2 and/or 3 were dishonest in that:

    a) You intended to conceal from Jardines Pharmacy that you supplied the medicines set out at 1 above.

    b) You intended to conceal from Jardines Pharmacy that you were offering and/or operating a medicine delivery service to Patient A, from Jardines Pharmacy.

6) On or around 5 September 2019 you supplied the following medications to Patient B when you did not have a valid prescription to supply them:

   a) Bisoprolol;
   b) Amitriptyline;
   c) Aspirin;
   d) Lisinopril;
   e) Simvastatin;
   f) Co-codamol.

7) You dispensed medications listed in allegation 6 above, without making a record of the supply on to Patient B's patient medication record.

8) You reprinted previously dispensed prescription labels of the medications listed in allegation 6 above and cut off the bottom of the labels containing Jardines Pharmacy details.

9) Your actions at 6 above was dishonest in that:

   a) Patient B was led to believe that the medicines at 6 above had been prescribed by their GP

10) Your actions at 7 and/or 8 were dishonest in that:

   a) You intended to conceal from Jardines Pharmacy that you supplied the medicines set out at 6 above.

   b) You intended to conceal from Jardines Pharmacy that you were offering and/or operating a medicine delivery service to Patient B from Jardines Pharmacy.

On or about 1 September 2020, in order to secure employment with MKGP Federation, you;

11) Created a fake email address in the name of 'Witness5@hotmail.com' in that:

a) It was not the email address of Witness 5
b) It was not an email address used by Witness 5
c) It was intended to appear that any email sent from this email address was from Witness 5

12) Created an employment reference containing incorrect and/or misleading information.

13) In respect of the employment reference at 11 above you falsified a signature of the referee.

14) You submitted the reference in the name of Witness 5 as set out at 12 above to MGKP Federation.

15) Your actions at 11, 12, 13 and 14 above were dishonest in that:

a) You knew the employment reference had not been completed by Witness 5
b) You knew the contents of the employment reference did not represent the views of Witness 5
c) It was intended to appear that the reference was from Witness 5 and/or represented the views of Witness 5

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

Documentation

- Council's Hearing bundle, of 161 pages containing witness statements and exhibits, and relevant emails;
- Council's Combined Statement of Case and Skeleton Argument of 10 pages dated 7 July 2023;
- Statement of Case and Skeleton Argument on behalf of the Registrant of 4 pages dated 17 July 2023;
- Registrant's bundle of 27 pages containing: Registrant's statement (undated and unsigned); Registrant's Statement to the police under caution dated 24 February 2021; references; evidence of professional courses he has attended; Registrant's action plan entitled: "Being honest: Steps to improve decision making", signed by the Registrant and dated 18 June 2021; and employment offer letter of 3 August 2021;
- Registrant's Reflective essay of 6 pages.

Witnesses

11. Witness statements from the following witnesses was relied on by the Council. The witnesses were not called to give oral evidence.

    - Witness 1
    - Witness 2
    - Witness 3
    - Dr 1
    - Witness 4
    - Witness 5

Registrant's response to Particulars of allegation

12. Mr Hadley, on behalf of the Registrant, admitted all of the facts alleged in the Particulars of Allegation. Mr Hadley accepted on the Registrant's behalf at the outset of the hearing that the facts found proved amount to misconduct and that Rules 5(2)(b) and (c) of the Rules are engaged.

DETERMINATION ON THE FACTS

13. In the light of the above, and by the application of Rule 31(6) of the Rules, the Chair announced that the admitted factual particulars were found proved.

STAGE TWO: Misconduct and Impairment

14. Having found all the factual particulars of allegation proved, the Committee went on to consider whether those particulars amounted to misconduct and, if so, whether the Registrant's fitness to practise is currently impaired.

Background

15. The facts as agreed by both parties are summarised below.

Evidence of Witness 1

16. Witness 1 is a director of Jardines (UK) Limited ('the pharmacy') and oversees the community pharmacy aspect of the business. He stated in his witness statement that the Registrant starting working at the pharmacy on a locum basis around February or March 2019. On 06 September 2019 Witness 1 received three photographs from a member of staff showing that the Registrant had generated prescription labels the previous day for two patients (referred to within the allegations as Patient A and Patient B). Witness 1 stated that the bottom of those labels showing the medication was from the pharmacy had been cut off and the labels had then been attached to prescription-only medications. It was said that the Registrant had then put these medications into his bag before leaving the pharmacy.

17. That evening Witness 1 and his father met with the Registrant; the Registrant told

them he was delivering medications and was awaiting prescriptions which he had been told by the surgery would be forthcoming. The Registrant apologised for his actions.

18. Witness 1 subsequently contacted the GP surgery regarding the medications for Patients A and B and was told that no medications had been ordered.

19. The Registrant is said not to have provided an explanation as to why he cut off the pharmacy details from the label. Witness 1 says he had carried out some online research and found that the Registrant was a director of a company called JR Medicall Limited, and that the nature of the business was as a dispensing chemist within specialised stores. The Registrant told Witness 1 this was a dormant company that had not been in operation.

20. Witness 1 says that when he told the Registrant he would be contacting Patient A and Patient B, the Registrant said that he was signing them up to a service whereby he would manage their repeat medications but not charge them any money. He said he would approach patients to sign them up to a repeat service, would manage the ordering and delivery of their medications and that they could look 'together' at charging a fee in the future. Witness 1 explained that pharmacies in Milton Keynes CCG were not allowed to order medications on behalf of the patients and the Registrant said he was unaware of this.

21. Witness 1 visited the Registrant's house and saw a file with the words 'JR Medicall' on it, with a company logo and the NHS logo. Marketing leaflets were available saying that services provided would be that a registered pharmacist would manage and deliver medications to the patients' door. Witness 1 saw the details of Patients A and B within this file and saw they had signed to authorise direct debits to the Registrant; the Registrant said these two patients were the only two patients he had signed up.

22. Witness 1 explains that on 9 September 2019 the Registrant visited Witness 1 and was

apologetic and remorseful of his actions.

Evidence of Witness 2

23. Witness 2 is the Lead Medicines Optimisation Technician employed by Luton and Milton Keynes CCG. She explained in her witness statement that in 2019 pharmacies were asked to help their GP practices identify vulnerable patients who may still require third party re-ordering, although it was for GPs to ultimately decide and action appropriately.

Evidence of Witness 3

24. Witness 3 is a Professional Services Manager employed by Jardines (UK) Limited. She stated that on 12 September 2019 she reported the concerns about the Registrant's conduct.

Evidence of Dr 1

25. Dr 1 is a doctor and GP Partner working at Hilltops Medical Centre.

26. Dr 1 stated that the Registrant used to work at the pharmacy next door to the surgery and once the surgery had a vacancy, the Registrant was offered employment by Hilltops Medical Centre through MKGP Federation. He was due to start the position on 1 October 2020.

27. Dr 1 stated that the Registrant was asked by the Practice Manger for details in order to request references. One referee was the pharmacist who was his boss at the Hilltops Pharmacy, witness 5 – this was his current employer. Another referee was another pharmacist with whom the Registrant had previously worked.

28. Dr 1 explained that the two referees provided satisfactory references and so the Medical Centre asked MKGP Federation to employ him on their behalf.

29. Dr 1 recalled that Witness 5 was made aware that a reference had been provided in her name and so the Practice Manager was asked to provide the email address, which Witness 5 confirmed did not belong to her. They then informed MKGP Federation of the discrepancy.

Evidence of Witness 4

30. Witness 4 is the Pharmacist Lead Ambassador employed by MKGP Federation.

31. Witness 4 stated in his witness statement that he had known the Registrant for three years and that the Registrant had worked in the Hilltops Pharmacy whilst Witness 4 had worked in the accompanying GP Surgery.

32. Witness 4 interviewed the Registrant for the position at the Surgery in September 2020, alongside Dr 1. The Registrant was to be responsible for providing the completed HR paperwork, including references, which he provided to the surgery who then forwarded them to MKGP Federation.

33. Witness 4 says the references in question were signed by Witness 5 and her husband.

34. Witness 4's evidence is that the Registrant started in employment on 2 November 2020 and during the second week of November he received a telephone call from the HR Manager about concerns with the references provided by the Registrant. He then telephoned the Registrant and asked him to go home pending an investigation.

35. A meeting took place on 16 November 2020, in which the Registrant admitted

falsifying the reference and said that he had signed the document on Witness 5's behalf and had completed the reference himself. The Registrant admitted making up the email address and said he was worried Witness 5 would not sign the reference.

Evidence of Witness 5

36. Witness 5 is a Pharmacist working at the Hilltops Pharmacy; she is also the owner, general manager and Superintendent. She explains that the Registrant stopped working for Hilltops Pharmacy in October 2020 and that was the last time she spoke with him; she had understood he had a job elsewhere.

37. Witness 5 says she had a passing conversation with a doctor at the Hilltops Medical Centre who told her the Registrant had been given a job at the surgery. She was told that he had been employed because of her 'glowing reference'. Witness 5 said she was surprised and 'aghast' when she realised the Registrant had submitted the version he had drafted himself, and that she noted her husband's signature was on the bottom of it.

38. Witness 5 confirmed in her statement at paragraph 12 as follows:

"I confirm that I have viewed the reference and that I did not write it and my husband did not sign the document in question. The email used [to send the reference] is also not mine".

Submissions and Evidence

39. The Committee took account of the guidance given to the meaning of 'fitness to practise' in the Council's publication *"Good decision-making"* (Revised March 2017). Paragraph 2.11 reads:

"A pharmacy professional is 'fit to practise' when they have the skills, knowledge, character, behaviour and health needed to work as a pharmacist…safely and effectively. In practical terms, this means maintaining appropriate standards of competence, demonstrating good character, and also adhering to the principles of good practice set out in your various standards, guidance and advice."

40. The Registrant gave evidence, in which he described his insight into the seriousness of the factual findings, expanded upon and confirmed his regret and remorse for his conduct, and explained to the Committee what actions he had taken by way of remediation.

Submissions

41. Ms Vanstone, on behalf of the Council, drew the Committee's attention to the relevant case law and submitted that the Registrant's dishonest conduct breached Standards 1, 2, 5 and 6 of the Standards for pharmacy professionals (May 2017). She submitted that his dishonesty which took place on two separate occasions was plainly so serious as to amount to misconduct. In relation to current impairment, Ms Vanstone submitted that Rules 5(2) (b) and (c) of the Rules were engaged by the Registrant's actions. She submitted that, taking into account the guidance in the case of CHRE V NMC & Grant [2011] EWHC 927 (Admin), the need to uphold professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in these circumstances.

42. Mr Hadley accepted that the facts found proved, to which the Registrant had made full admissions, amounted to misconduct. In relation to current impairment, Mr Hadley accepted that Rules 5(2) (b) and (c) were engaged. In relation to whether the Registrant as at today's date, presents a risk to patients or the public, Mr Hadley submitted, drawing the Committee's attention to all of the evidence of regret, insight, remorse and remediation that was before it, that the Registrant had sufficiently remediated his conduct such that the Committee could conclude that he was unlikely to repeat his conduct. Mr Hadley referred to the Registrant's Reflective

Essay and his oral evidence; his unblemished record of working both before and, significantly, after the events in question; his positive testimonials from referees including his current line managers; the remedial training he had undertaken including in relation to ethics and probity; and the action plan provided by the Registrant. He submitted that, taking all of the evidence into account, the Committee ought to find that Rules 5 (2) (a) and (d) are not engaged in that the Registrant, as at today's date, does not present an actual or potential risk to patients or the public; and is not a person whose integrity cannot be relied upon.

Decision on Misconduct

43. When considering whether the particulars found proved amounted to misconduct the Committee took into account the Council's *Good decision making guidance (2017)*.

44. The Committee accepted the submissions of Ms Vanstone in relation to the Council's Standards for Pharmacy Professionals (May 2017). It determined that there had been breaches of the following Standards:

    a. **Standard 1: Pharmacy professionals must provide person-centred care:** The Registrant breached this standard in that he dishonestly dispensed prescription-only medication to two patients without prescriptions, using labels which had been reprinted from earlier dispensing, and with the name of the pharmacy removed. He omitted to record the dispensing on the patients' medication records. These patients, by his own account were vulnerable.

    b. **Standard 2: work in partnership with others:** The Registrant dishonestly removed medication from the pharmacy where he was working as a locum and did not tell his employers what he was doing.

    c. **Standard 5: use professional judgement:** The Committee is of the view that the Registrant breached this standard on both occasions, both in relation to dispensing medication to Patients A and B in 2019 and when falsifying a reference

in 2020, acting, at the time, in relation to both matters, as he admitted himself, for “selfish” motives.

d. **Standard 6: behave in a professional manner: [be] trustworthy and act with honestly and integrity:** The Registrant’s dishonest conduct both in 2019 and again in 2020, breached this standard.

45. The Committee bore in mind that the Standards may be taken into account when considering the issues of grounds and impairment but that a breach of the Standards does not automatically result in a finding of misconduct (Rule 24(11) of the Rules).

46. The Committee considered that the facts found proved were very serious.

47. In relation to Patients A and B, the Registrant has admitted, and the Committee has found, that he dishonestly supplied multiple prescription-only medications to two patients who he himself has admitted were “vulnerable”, without prescriptions. He admitted to the Committee in oral evidence that he did not request repeat prescriptions from the patients’ GPs (although he told the police that he had done so); and moreover he deliberately tore or cut off the parts of medication labels which showed the name of the pharmacy he had taken the medications from. He did not record the dispensing in the patients’ medication records. The Registrant’s intention was to conceal the full nature of his conduct both from the pharmacy and from the patients. The evidence before the Committee in relation to the full context is that the Registrant was arranging to be in a position to have funds transferred from the patients’ bank accounts to his own account, by way of direct debits. The Committee understands that the Registrant in fact made no financial gain: his dishonesty was uncovered on the day he took the medication from the pharmacy. The Registrant had used his interviews with Patients A and B for Medication Use Reviews (MURs) to introduce the service he was setting up.

48. In relation to the fabricated reference from Witness 5, the Committee took into account that this was premeditated and required planning. The Registrant created a false email account from which he sent the reference, intending the recipients to conclude that it had legitimately been written and sent by Witness 5; he also obtained her husband's signature and falsely signed the document in her name.

49. In the Committee's view, the Registrant's dishonesty as set out in the factual particulars fell far below what would be expected of him by fellow practitioners and would be likely to be considered reprehensible and deplorable by them.

50. Accordingly, in the judgement of the Committee, the ground of Misconduct is established.

Decision on Impairment

51. Having found that the factual particulars of allegation amounted to misconduct, the Committee went on to consider whether the Registrant's fitness to practise is currently impaired. It applied the well-known guidance of Mr Justice Silber in Cohen v General Medical Council [2008] EWHC 581 (Admin) at paragraph 65:

"It must be highly relevant in determining if a [registrant's] fitness to practice is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated".

The Committee was aware that these principles are echoed in the Council's Guidance at Paragraph 2.14. It also took into account the principles set out in Yeong v General Medical Council [2009] EWHC 1923 (Admin) in which Mr Justice Sales said at paragraph 21:

"It is a corollary of the test to be applied and of the principle that a FTPP is required to look forward rather than backward that a finding of misconduct in the past does not necessarily mean that there is impairment of fitness to practise…In looking forward, the FTPP is required to take account of such matters as the insight of the practitioner into the source of his misconduct, and any remedial steps which have been taken and the risk of recurrence of such misconduct. It is required to have regard to evidence about these matters which has arisen since the alleged misconduct occurred."

52. The Committee gave credit to the Registrant for his full and frank admissions both in relation to the facts alleged and also for his insight into their seriousness. It took full account of his Reflective Essay in which he sought to demonstrate his insight, his developed understanding of the potential risk of harm to patients in relation to his conduct both in 2019 and 2020, and his regret and remorse. It took into account comments made by the Registrant in his Essay. In relation to his conduct in 2019 he wrote: "To Jardines and those patients involved there was a breach of trust between them and I, the pharmacist", and in relation to the false reference in 2020, he admitted that he "simply had selfish reasons as I sought to benefit myself only…it was selfishness that led me to a dishonest act".

53. The Committee also took into account all of the Registrant's oral evidence and the positive references he had provided. It noted that in addition to references from his fiancée and a close friend, who is a doctor, he had provided references from his managers, both registered health professionals, at his current places of work. It noted that all the referees had been informed of the allegations before this Committee and confirmed their opinions that he had learned from his previous dishonest conduct and is now honest and trustworthy. The Committee also took into account that the Registrant has undertaken some training including in relation to safeguarding adults and children, ethics and probity. It took into account his acknowledgement in evidence that although the courses did not concentrate in depth on the question of dishonesty, he had found them helpful nevertheless in assisting his development as a more mature and responsible pharmacist than he was

at the time of the events in question. It appreciated that he had admitted that there are more courses he has identified which he would like to attend in order to continue with his reflections and remediation in relation to his previous dishonesty and further embed the changes he has made to his practice.

54. However, the Committee remained concerned that the facts found proved amounted to serious and premeditated dishonesty on two separate occasions in two entirely different contexts. It noted the Registrant's own admission in his Reflective Essay that "the brutal truth is that I did not learn my lesson the first-time round". It noted that there were inconsistencies between the account which the Registrant gave in oral evidence and what he told the police in his statement under caution, for example in relation to whether he had in fact requested a prescription from the patients' GP before dispensing repeat medication to them. Applying the considerations set out in the case of Cohen, the Committee was of the view that the dishonesty found proved was not "easily remediable" because, although the dishonest conduct took place on two separate occasions and at two different times, and consisted of quite different actions, what united both events appeared to be an attitude on the Registrant's part which placed considerations of self- interest above the interests of his patients and his employer.

55. The Committee carefully considered the Registrant's "action plan" dated 18 June 2021, in which he had written out "A step by step guide on how to be honest in real life situations". It was concerned that the "steps" included several requirements to consult managers or colleagues yet did not in fact refer, other than in the title, to dishonesty at all, or, more particularly, to how the Registrant might in future desist from being dishonest again. The Committee was also concerned that although the Registrant had properly and genuinely expressed remorse for his misconduct, and demonstrated insight into the risks of harm to patients, the harm to his employers on both occasions, and the harm to confidence in his profession, nevertheless he had not been able fully to explain to the Committee why he acted as he did – for example in taking and dispensing the medication without recording this in the patients'

medication records, and removing the name of the pharmacy from the labels - and was inconsistent in relation to some of his evidence – for example about whether or not he had requested prescriptions from his GP and whether and why he had told the police that the dispensing was by way of an "emergency supply". The Committee took full account of the fact that the Registrant has been working as a registered practitioner both in community pharmacy and in a hospital in oncology since the events four years ago, with no further concerns having been raised. However it was not reassured that, despite his written and oral evidence, and the positive references, the Registrant would not, if circumstances offered themselves on a future occasion, and the Registrant was faced with a conflict between his own interest and those of his patients or of his profession, choose to act dishonestly again.

56. The Committee has concluded that the Registrant's conduct that led to the allegation has not been sufficiently remedied and it does not consider that it is highly unlikely to be repeated.

57. In the light of these observations, the Committee turned to consider whether any sub-particulars of Rule 5(2) of the Rules are engaged by the Registrant's misconduct. Given its conclusions above, the Committee is of the view that Rule 5(2)(a) is engaged, in that the Registrant currently *"presents an actual or potential risk to patients or to the public"*.

58. The Committee is also satisfied that the Registrant's misconduct clearly has brought the profession of pharmacy into disrepute (Rule 5(2)(b)), and that in breaching the standards for pharmacy professionals as set out above, he breached one or more fundamental principles of the profession (Rule 5(2)(c), for example, the requirements to be honest and to act in the best interests of patients. The Committee is also of the view that given the fact that its factual findings amount to repeated dishonesty suggestive of an attitudinal issue, the Registrant's integrity can no longer be relied upon – thereby engaging Rule 5 (2) (d) of the Rules.

59. In relation to the public interest, the Committee bore in mind the well-known words

of Mrs Justice Cox in the case of *Grant,* in which she stated that a panel must consider whether *"the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances"* of a case. The Committee is of the view that its findings of fact in this case are such that the public would expect a finding of current impairment of fitness to practise in order to maintain professional standards and uphold confidence in the profession and in the regulator itself.

60. For all the reasons set out above, the Committee therefore finds the Registrant's current fitness to practise to be impaired on public protection and public interest grounds.

Decision on Sanction

61. Having found impairment, the Committee has gone on to consider the matter of sanction. The Committee's powers are set out in Article 54(2) of the Order. The Committee should consider the available sanctions in ascending order from the least restrictive, taking no action, to the most restrictive, removal from the register, in order to identify the appropriate and proportionate sanction that meets the circumstances of this case.

67. The purpose of the sanction is not to be punitive, though a sanction may in fact have a punitive effect. The purpose of the sanction is to meet the overarching objectives of regulation, namely the protection of the public, the maintenance of public confidence and to promote and uphold professional standards. The Committee is therefore entitled to give greater weight to the public interest over the Registrant's interests.

Submissions

68. Ms Vanstone submitted that given the Committee's findings, no less a sanction than removal was proportionate because the Registrant's dishonest conduct was fundamentally incompatible with remaining on the Register.

69. Mr Hadley summarised all the efforts the Registrant has gone to remediate his misconduct, including all of the documentary evidence and the Registrant's oral evidence. He drew the Committee's attention to the fact that the Registrant was at the start of his career when he acted as found proved, and like everyone, he has learned and will continue to learn, from his early mistakes. He submitted that a member of the public if fully appraised of all of the evidence would consider that a warning, or conditions of practice with a review, or a period of suspension (the shortest appropriate), would satisfactorily mark the public interest in the case. He submitted that the Registrant has a right to work and there is a need for professionals to work in pharmacy. Therefore removal from the Register would be disproportionate.

Decision

70. The Committee had regard to the Council's *'Good decision making: Fitness to practise hearings and sanctions guidance (2017)'* ("the Sanctions Guidance"), to inform its decision.

71. The Committee took into account the submissions made by Ms Vanstone and Mr Hadley.

72. The Committee first considered what, if any, aggravating and mitigating factors there may be.

73. The Committee identified the following aggravating factors:

a. The Registrant exploited vulnerable patients;
b. His conduct took place during the course of his work as a pharmacist;
c. His falsification of the reference was a breach of trust against his employer;
d. He abused his professional position as a pharmacist at Jardines pharmacy, and for personal financial gain;
e. The dishonesty took place on two occasions separated by approximately one year, in very different contexts;
f. On both occasions of dishonesty, there was a significant degree of planning.

74. The Committee identified the following mitigating features:

a. The Registrant admitted the facts and conceded that they amounted to misconduct;
b. He has an otherwise unblemished career;
c. No actual harm caused to patients;
d. He has shown some insight into his actions, remorse and regret
e. He has made efforts to remediate his conduct;
f. Positive personal and professional references.

75. Take no Action: The Committee first considered where it would be appropriate to take no action, however it was of the view that neither of these two outcomes would protect the public nor would they be sufficient to reflect the seriousness of the Registrant's misconduct.

76. Warning: The Committee next considered whether issuing a warning would be appropriate but it decided that a warning would not protect the public nor sufficiently mark the public interest.

77. Conditions of Practice. The Committee next considered whether to impose conditions of practice. A Conditions of Practice Order would allow the Registrant to practise albeit with restrictions. The Committee took into account that it had been concerned about the Registrant's attitude to his professional role, in that on two separate occasions he had acted selfishly and dishonestly to further his own interests above those of patients or his profession. It determined that no conditions of practice could be formulated which would mitigate the risk of the Registrant repeating his conduct. In any case, the Committee was of the view that an order of conditions would not be sufficient to mark the seriousness of the matter so as to maintain public confidence in the Registrant, the profession and the regulator, and sufficient to promote professional standards within the profession.

78. Suspension Order. The Committee next considered whether suspension would be a proportionate sanction. The Committee noted the Council's Sanctions Guidance which indicates that suspension may be appropriate where:

> "*The Committee considers that a warning or conditions are insufficient to deal with any risk to patient safety or to protect the public, or would undermine public confidence. It may be required when necessary to highlight to the profession and to the public that the conduct of the registrant is unacceptable and unbefitting a member of the pharmacy profession. Also, when public confidence in the profession demands no lesser sanction."*

79. The Committee accepted Ms Vanstone's submission to the effect that there is a fine balance between suspension and removal. It very carefully considered the relative merits of both forms of sanction.

80. It took into account paragraphs 6.8 and 6.9 of the Sanctions Guidance in relation to dishonesty, relevant parts of which are set out below:

" 6.8…The GPhC believes that dishonesty damages public confidence, and undermines the integrity of pharmacists…However, cases involving dishonesty can be complicated – committees should carefully consider the context and circumstances in which the dishonesty took place. Therefore, although serious, there is not a presumption of removal in all cases involving dishonesty…

6.9 Some acts of dishonesty are so serious that the committee should consider removal as the only proportionate and appropriate sanction. This includes allegations that involve intentionally defrauding the NHS or an employer, falsifying patient records, or dishonesty in clinical drug trials."

81. The Committee took into account the following factors. The Registrant was at the start of his career when the events in question occurred and, whilst it is of the view that his dishonest conduct is not easily remediable, it does consider that his conduct can, in principle, be remedied. The Registrant has worked as a pharmacist for quite

some time since the events without further concerns. The Committee placed weight on the contents of the Registrant's professional references from his managers at the two places he works, his employment at Buckinghamshire Health Care Trust, and his locum engagement at Tesco Pharmacy in Aylesbury. They both addressed the issues of dishonesty at the heart of this case, and suggested that the Registrant is capable of sufficiently remedying his misconduct and embedding it into his practice in due course. The Committee accepted the submissions of Mr Hadley to the effect that he has expressed remorse and apologised for the harm caused to all those involved including his employers, the patients, his family and friends, his profession and the public interest. He has made efforts to remediate his conduct by way of training, providing a detailed Reflective Essay, and the writing up of an action plan. The Committee would reiterate at this point however that the action plan, requiring as it does, that he ask advice from mentors and colleagues, did not persuade this Committee that he can himself currently in fact be trusted to know not to behave dishonestly. He should not need to ask others.

82. The Committee carefully weighed the seriousness of the Registrant's proven dishonesty with the mitigating factors in this case, as set out above. Whilst it agreed with Ms Vanstone who submitted that his conduct could be construed as fraudulent and it was certainly an abuse of trust, both in relation to Patients A and B and to his two employers, the Committee accepted the submissions of Mr Hadley that the Registrant's conduct did not fall into the most serious category of misconduct.

83. The Committee is satisfied that a period of suspension will enable the Registrant to continue with the reflective and remediation work he has begun. It decided that suspension for a period of 12 months will properly and sufficiently mark the seriousness of his misconduct, and maintain confidence in the profession and in professional standards.

84. Removal. Having concluded that a period of suspension would satisfactorily deal with the issues of public protection and public interest which it has identified, the Committee considered whether removal was in fact more appropriate. The Committee took into account that removal is to be reserved for the most serious failings. It agreed with Mr Hadley that, when all the facts of this case are properly weighed against the Registrant's right to practise in his chosen profession and the public need for pharmacists who are good at their job, (taking into account the Registrant's references which attest to his good standard of clinical practice), removal would be disproportionately punitive at this stage.

85. The Committee therefore directs that the entry in the Register of Mr Jodhan Reehal be suspended for a period of 12 months.

Review Hearing

86. The Committee directs that the suspension should be reviewed before its expiry. The Reviewing Committee may be assisted at the review by the following:

a. Testimonials in relation to any work undertaken by the Registrant, whether paid or voluntary;
b. Evidence of any targeted training and CPD;
c. A reflective document explaining how the multiple particulars relating to his dishonesty occurred, what his thought process and plans were at the time, and how his insight into his dishonesty has further developed.

Decision on Interim Measure

87. Ms Vanstone for the Council, made an application for an interim measure of suspension to be imposed on the Registrant's registration, pursuant to Article 60 of the Pharmacy Order 2010, pending the coming into force of the Committee's

substantive order. She submitted that such an order was necessary to protect the public and was otherwise in the public interest. The Committee also took into account the Council's Sanctions Guidance of 2017.

88. Mr Hadley opposed the application, pointing out that the Registrant has worked with no concerns raised in relation to his practice for over 30 months or so, and has supportive references to this effect.

89. The Committee carefully considered the Council's application. It took account of the fact that its decision to order the suspension of the Registrant's name from the register will not take effect until 28 days after the Registrant is formally notified of the outcome, or until any appeal is concluded.

90. The Committee has found that the Registrant's misconduct merits an order of suspension, not only on public interest grounds but also because in the Committee's view, there remains a risk that the Registrant might repeat his conduct. It is satisfied that it is therefore necessary for an interim measure of suspension to be in place from today's date.

91. The Committee therefore hereby orders that the entry of the Registrant in the register be suspended forthwith, both on grounds of public protection and in the public interest, pending the coming into force of the substantive order.

92. This concludes the determination.