General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote video link hearing

31 July - 2 August 2023

Registrant name:	Rebecca Faye Platt
Registration number:	2073233
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Philip Geering (Chair) Surinder Bassan (Registrant Member) Nalini Varma (Lay Member)
Legal Adviser:	Andrew Clemes (31 July 2023) Graeme Henderson (1 August 2023) Andrew Clemes (2 August 2023)
Committee Secretary:	Zainab Mohamad
Registrant:	Not present and not represented
General Pharmaceutical Council:	Represented by Dr Francis Graydon of Counsel, Case Presenter
Facts proved:	1, 1.1, 1.2, 1.3, 2.1, 2.2, and 3
Fitness to practise:	Impaired
Outcome:	Suspension for 6 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 30 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.

Particulars of Allegation (as amended)

You, a registered pharmacist, Between March 2020 and October 2020, as the regular responsible pharmacist (RP) at Well Meddyula Twyn, Buch, Burry Port SA16 0BN (the pharmacy)

1. Dispensed controlled drugs (CD's) to the following patients often without a prescription:

1.1 Patient A between 3 April 2020 and 5 October 2020

1.2 Patient B between 6 April 2020 and 19 October 2020

1.3 Patient C between 27 August 2020 and 19 October 2020

2. Failed to ensure the safe dispensing of controlled drugs in that you:

2.1 Dispensed and self-checked controlled drugs

2.2 Instructed and / or allowed dispensers to give controlled drugs to patients without the knowledge or supervision of the Responsible Pharmacist on duty at the time.

3. Failed to report these incidents on the company reporting system (DATIX) in a timely fashion despite being requested to do so.

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

Documentation

Document 1- GPhC hearing bundle indexed and paginated 1 - 194

Document 2- GPhC skeleton argument dated 21/7/2023

Document 3 – Guide to redactions and abbreviations (one page)

Document 4 – copy of signed version of Witness 2's statement dated 26/7/2023 (replacing the unsigned version in the hearing bundle

Document 5 – Proof of Service bundle

Document 6 – GPhC bundle for an application to proceed in the Registrant's absence

Witnesses

Witness 1

Witness 2

Determination

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 been provided with a 'Proof of Service' bundle. It includes a letter dated 27/6/2023 from the Council headed 'Notice of Hearing' addressed to the Registrant.

7. The committee was satisfied that there had been good service of the Notice in accordance with Rules 3 and 16.

Application to proceed in the absence of the registrant

8. On behalf of the Council, an application was made under Rule 25 to proceed in the absence of the Registrant. On behalf of the Council, it was submitted that she had voluntarily absented herself and that there was no evidence that she would attend an adjourned hearing.

9. The committee received and accepted legal advice.

10. When a registrant is absent from a hearing, and not represented, the committee may nevertheless proceed with the hearing if it is satisfied that (a) service of the Notice of Hearing has been properly effected, or (b) all reasonable efforts have been made to serve the registrant with the Notice (Rule 25 of the 2010 Order).

11. The committee therefore has a discretion to determine that the hearing proceed in the absence of the Registrant.

12. The committee approached its consideration of the application with great care and caution.

13. The committee has already determined that the Notice of Hearing has been properly effected. The committee has also seen evidence that correspondence has been sent to her both electronically and by post, and that repeated efforts have been made to make contact with her over many months including up to last week.

14. The committee decided that it should proceed in the absence of the Registrant. It did so for the following reasons.
    a. There is evidence that the Council has sought to correspond with the Registrant using contact details that had previously elicited a response but that since December 2021 there has been no response from the Registrant.
    b. In the absence of evidence of an alternative explanation for the Registrant not responding (such as medical evidence or a change of address), the committee concludes that the Registrant has voluntarily absented herself from the proceedings.
    c. There is no evidence that she has sought an adjournment or to suggest that if the hearing was postponed that she would attend at a later date.
    d. The allegation raises issues that go to patient safety and there is, accordingly, a public interest in the matter being progressed in a timely fashion.
    e. Not proceeding today would inconvenience witnesses who are ready to give evidence.

f. There is in any event a public interest in legal proceedings being concluded expeditiously.

15. Accordingly, the committee has determined that the balance of interests clearly favours the public interest in this hearing proceeding albeit in the absence of the Registrant.

16. The committee makes it clear that it does not hold against her the fact that she has not attended the hearing. That is her right. The committee has focused on the evidence available to it on which to make decisions and has sought to ensure the process has been fair irrespective of her absence.

17. The committee therefore grants the application and directs that the hearing should proceed in the absence of the Registrant.

Application to amend the particulars of allegation.

18. The committee heard an application on behalf of the Council under Rule 41 to amend particular 1.

19. Particular 1 originally read as follows:

"1. Dispensed controlled drugs (CD's) to the following patients often without a prescription and without being labelled or recorded on the patient medication record (PMR):):

1.1 Patient A between 3 April 2020 and 5 October 2020

1.2 Patient B between 6 April 2020 and 19 October 2020

1.3 Patient C between 27 August 2020 and 19 October 2020"

20. The application was to remove the words *"and without being labelled or recorded on the patient medication record (PMR):)".*

21. The application was made, it was submitted, on the basis that the amended allegation would more accurately reflect the evidence, and to a degree reduced the seriousness of the allegation whilst continuing to reflect the overall seriousness of the matter.

22. The committee accepted the advice of the Legal Adviser, in particular that the committee has a discretion to amend the allegation but that it should act fairly to both parties.

23. The committee was of the view that it would be appropriate to grant the application. The committee concluded that making the amendment, whilst making it easier to prove, it would more accurately reflect the circumstances of the case without substantially changing the nature of the allegation and therefore the Registrant would not be unduly prejudiced by the amendment.

24. Accordingly, the application to amend was granted.

The Registrant's dismissal

25. The fact that the Registrant was dismissed by her employer following a disciplinary process was apparent on the face of the documents available to the committee.

26. For the record, and out of fairness to the Registrant, the committee records that it has placed no weight on the fact of the dismissal. This committee is independent and operates within a regulatory context. It will make its own determinations of the allegations based on an objective assessment of the evidence that it has available to it. To that end, the views and decision of the employer's disciplinary panel are of no relevance to the committee.

27. On behalf of the Council, Dr Graydon raised no objection to the committee being aware of the fact of the dismissal and was content with the committee adopting the stance set out above.

Registrant's response to Particulars of allegation

28. In the absence of the Registrant or any written submission from her, the Council was put to proof regarding the allegation.

Background

29. The Registrant was first registered as a Pharmacist with the Council in 2010. Her registration number is 2073233.

30. The allegation against her concerns her conduct as a pharmacist in her workplace at the Well Pharmacy, Burry Port branch in Wales ('the pharmacy'). The pharmacy is part of a wider chain of pharmacies operated by a company to which the registrant would report. The Registrant had worked with the company for about three-and-a-half years and had been branch manager for about two-and-a-half years by the time concerns came to light.

31. In short, it is alleged that the Registrant supplied Controlled Drugs to three patients without a prescription for periods of up to several months in 2020, that she followed unsafe procedures in relation to the supply, and that she did not report all incidents promptly to her employer when required to do so.

32. On 7/10/2020, a local GP reported a concern to the Local Health Board. The report concerned a patient, Patient A, who was under the care of the local Drug and Alcohol Team ('DAT'). Patient A had been receiving medication but the last prescription supplied was in April 2020. Patient A had subsequently advised the GP surgery that she had continued to receive medication from the pharmacy since April 2020 up to the time of reporting in October 2020.

33. The circumstances in which this came about appear to be as follows. Patient A was under the care of both her GP surgery and the DAT. Her treatment included the provision of a prescription for controlled drugs to help with her treatment. Patient A

was transferred from another pharmacy to the Registrant's pharmacy during the Covid 19 pandemic lockdown to reduce the need to travel to collect her medication. The evidence of Witness 1 was that at that time communications broke down between the GP surgery and the DAT, with each thinking the other was continuing to provide a prescription when in fact neither was doing so. Without, it seems, being aware of the absence of a prescription, Patient A continued to attend the Registrant's pharmacy to collect her medication. The Registrant's evidence in her employer's disciplinary interview was that matters came to light when Patient A *"asked GP for a longer prescription due to going on holiday"* which prompted the GP surgery to make inquiries and then report matters to the Local Health Board.

34. This matter was brought to the attention of Witness 1 who was the area Lead Cluster Pharmacist at the Local Health Board. On the same day that the concern was raised with the Local Health Board, Witness 1 contacted the Registrant. It is reported that the Registrant confirmed that drugs had been supplied to Patient A over the period April to October 2023 and she also confirmed that there was no repeat prescription covering that supply of the drugs. The Local Health Board provided the Registrant with a blank Incident Report Form asking her to complete it, which the Registrant did regarding Patient A, signed and dated 10/10/2020, and returned it to the Local Health Board.

35. Witness 1's evidence is that the Registrant herself then started to check her records to identify other instances of patients being supplied controlled drugs without a prescription. The Registrant then completed further Incident Report Forms concerning two further patients, Patients B and C, and sent them to Witness 1.

36. On 12/10/2020, a further similar concern involving a second patient was identified and on 13/10/2020 the Local Health Board reported the matter to the Council and the Registrant's employer. Thereafter a further concern came to light involving a third patient.

37. Inquiries revealed the following:

    a. Patient A had been on prescriptions as follows:

i. Buprenorphine 8.4mg daily with the last prescription being issued on 2/4/2020 for 14 days.

ii. Transtec patches 35ug applied twice a week with the last prescription issued on 3/4/2020 for 14 days.

iii. Pregabalin 300mg twice daily, with the last prescription issued 30/4/2020 for 14 days.

Patient A advised her GP that she had continued to receive the medication up to the October date when matters came to light at a time when there were no prescriptions in place for the supply. She was supplied them on a twice weekly collection from the pharmacy.

b. Patient B had been on a prescription for:

i. Diazepam 5mg, and

ii. Pregabalin 300mg

with the last prescription being issued on 6/4/2020. Witness 1's evidence, which the committee accepts, was that such prescriptions would normally be for two weeks and would not have covered the period to October. This matter came to light on 12/10/2020 when the GP informed the Local Health Board of it. The Registrant subsequently provided an Incident Report Form dated 19/10/2020 in which she reports that the pharmacy *"hadn't received new prescription since 6/4/20."*

c. Patient C had been on a prescription for:

i. Espranor 8mg 1 per day; and

ii. Espranor 2mg, 1 tablet three times per day

The Registrant completed an Incident Report Form dated 19/10/2020 on which she has reported that no prescription had been issued covering the fortnight period of 30/9/2020 to 12/10/2020, but that Patient C *"had been supplied* [the drugs] *assuming there was a current prescription."*

38. The matter was the subject of an investigation by the Local Health Board and the Registrant's employers. The employer's investigation included formal interviews of

the Registrant and other staff, interviews that were contemporaneously recorded in written form. The Local Health Board reporting the matter to the Council on 12/10/2020 which then commenced an investigation for regulatory purposes.

39. The investigations report that there was no evidence of actual patient harm resulting from what had happened.

Decision on Facts

40. In reaching its decisions on facts, the committee considered the documentation listed at the start of this determination, oral evidence and the submissions made by the Council.

41. The committee accepted the advice of the legal assessor, in particular having regard to the burden and standard of proof, which is the civil standard meaning that particulars will be proved if the committee is satisfied that what is alleged is more likely than not to have happened, the need to consider each allegation individually, and the manner in which the Registrant's good character may be taken into account.

Particular 1

"1. Dispensed controlled drugs (CD's) to the following patients often without a prescription:

1.1 Patient A between 3 April 2020 and 5 October 2020

1.2 Patient B between 6 April 2020 and 19 October 2020

1.3 Patient C between 27 August 2020 and 19 October 2020"

42. The committee was satisfied that this particular was proved in its entirety, in respect of Patient A, Patient B and Patient C and over the time periods specified.

43. The evidence proving this particular appeared as follows:

a. The committee had three Incident Report Forms relating to the three patients. They are each hand written and signed in the Registrant's name. The evidence of Witness 1 from the Local Health Board was that she had sent the Registrant a blank form and the Registrant had returned the form three times, one for each of the three patients. The committee concluded that the three Incident Report Forms were contemporaneous records produced by the Registrant setting out what had happened;
b. The three forms acknowledged that Controlled Drugs had been supplied to the patients without prescriptions and she set out how she considered this had come about, in particular that the *"old prescription"* had been used "*thinking new prescriptions were automatically issued and stored..."* and *"as they* [the pharmacy] *were behind on paperwork."*
c. The committee also has hand-written contemporaneous records of interviews of the Registrant conducted by her employer as part of a disciplinary process and which are signed by the Registrant. Witness 2 confirmed the nature of the written records. In the written interview records, the Registrant is recorded as acknowledging she had been dispensing Controlled Drugs to the three patients relying on the *"old prescription"* and to a degree relying on the Patient Medical Records, and had assumed that new prescriptions had been provided but had not checked that this was the case.
d. In her interviews she accepted the seriousness of what she had done, accepted that she had been supplying Controlled Drugs illegally, and that she had felt *"sick"* when she realised.
e. The dates given in the particular coincide with the reports of when a prescription for the medication were last issued to each patient and the date when matters came to light at the Local Health Board. The committee also has a print out of the pharmacy's Patient Medical Records for each of the patients. This records when medication is dispensed for each patient. i.e. Bagged up ready for collection. The record shows the drugs being dispensed on occasions between the given dates. The Registrant accepts in her interviews that it was she who undertook the dispensing.

f. The committee was satisfied that there was evidence the Registrant dispensed controlled drugs on many occasions, more than sufficient to satisfy the description of *"often"* in the particular. Patient A alone attended twice a week over the relevant period which the Registrant describes as six months. The documents available to the committee include extracts from the pharmacy Patient Medical Records for Patients A, B and C. These record when medication was dispensed (i.e. Bagged ready for collection), dispensing undertaken by the Registrant. These records show over the relevant periods that over all the Registrant dispensed controlled drugs on many occasions and at a time when it is now known there was no relevant prescription in place.

44. In the light of the above, the committee was satisfied that Particular 1 was proved.

45. **This particular is therefore found proved.**

Particular 2.1

"2. Failed to ensure the safe dispensing of controlled drugs in that you:

2.1 Dispensed and self-checked controlled drugs"

46. The committee was satisfied that this particular was proved. In reaching this conclusion, the committee took account of the following:

a. In her interviews, referred to above, the Registrant confirmed that she was responsible for dispensing the Controlled Drugs. This was confirmed in the interviews of the two support staff and the locum pharmacist who worked with her.
b. In an interview on 30/10/2020 she is recorded as saying "*Yes, dispensed on Mondays and checked on day of collection. I appreciate that still means only 1 person."*
c. She went on to acknowledge that according to the SOP, self-checking should only occur *"in exceptional circumstances".* Asked if there were "always exceptional

circumstances" she replied *"Not always. I could of got someone to check there have been staffing issues (20 hour vacancy since March)".*

d. The evidence is that she worked with support staff who though not qualified to formally conduct a second check could have undertaken a basic check – Witness 1 described only self-checking on a handful of occasions in a thirty year career and that if there was a second person who could read English, they could undertake a check.

e. In addition, the Registrant worked with a second pharmacist. The Registrant did not work on Thursdays when, ordinarily, the other pharmacist would act as Responsible Pharmacist and could have undertaken a second check when supplying dispensed Controlled Dugs to a patient. However, the Registrant circumvented this opportunity to ensure safe practice by leaving dispensed medication that was to be supplied on Thursdays available for her support staff who she instructed to hand-over the medication to the patients. As the Registrant acknowledges in her interview, the Support Staff would not have known the medication was Controlled Drugs and would therefore not have been prompted to seek the Responsible Pharmacists approval for the Controlled Drugs to be supplied.

f. Witness 1 gave evidence that the Registrant could not effectively check or second check the medication because she did not have a current prescription.

47. The committee is satisfied that by routinely undertaking what she describes as a 'second check', the Registrant did fail to ensure the safe dispensing of Controlled Drugs as alleged in the stem of the allegation. The committee reaches this conclusion having taken into account the following:

a. The second check is written into the pharmacy's Standard Operating Procedures. It is also standard for the profession. It is there to ensure patient safety: as Witness 1 stated, human error is possible and a second check by another person who comes with fresh eyes can spot when error has occurred.

b. The second check is therefore an important part of ensuring patient safety.

c. The committee is satisfied that safety is ensured when required standard procedures are followed, and that safety is therefore not properly ensured if the required standard procedures are not followed.
d. In this instance, the Registrant has accepted not following the Standard Operating Procedure, accepted that she was self-checking, and, the committee concludes, she has not ensured the safe dispensing of Controlled Drugs.

48. The committee acknowledges that part of Witness 1's evidence was that if a pharmacist did have to self-check, then it is recommended that the pharmacist undertake other tasks first before returning to the dispensed drugs to undertake the second check. The Registrant stated in her interviews that whilst she dispensed on Mondays, she would conduct the second check when supplying the dispensed drugs to the patient. In this way, she may, to some limited degree, have mitigated her failure to ensure safety by not involving a second person to undertake the second check.

49. The committee has determined that safety is not properly ensured if the employer's required Standard Operating Procedures (SOPs) are not followed, and, SOPs are devised to ensure safe dispensing is emphasised given (a) the vulnerability of the patients concerned, as the medication was to treat drug addiction and misuse, and (b) the nature of the drugs involved. As for the nature of the drugs, all were controlled drugs where by legal and clinical requirements provide enhanced procedures for the storage, dispensing and supply of the medication. The committee accepted the evidence of Witness 1 regarding the nature of the drugs:

a. Buprenorphine is used to treat opioid misuse as a substitute which can provide benefits when its administration is under the supervision of clinicians but which can be addictive, is abused, is harmful if taken in excess and if less is taken than should be can leave a patient suffering from withdrawal symptoms;
b. Transtec is buprenorphine in the form of a patch with similar qualities described above;

c. Pregabalin is used as an analgesic mainly for neuropathic pain, is abused, can be harmful when taken in excess and has been linked to drug-related deaths, and if less is taken than should be patients may suffer pain;
d. Diazepam is used to treat anxiety, is abused, can be addictive, and can be harmful if taken in excess; and
e. Espranor is a sublingual (to dissolve under the tongue) brand version of buprenorphine with similar qualities described above.

50. The Registrant's failure to ensure safe dispensing of controlled drugs through dispensing and self-checking without a prescription is underscored by the 'safety-net' role she should have performed. It is apparent from the evidence that the three patients should have been prescribed medication but in error, for periods of time, were not. Had the Registrant checked for a prescription as she should have done, the error by those responsible for prescribing would have been identified sooner and corrected, thereby ensuring that a clinically correct, and therefore safe, prescription was issued.

51. The fact that no patient harm has been identified as a result of the Registrant's conduct does not, in the committee's judgement, mean that the Registrant did not fail to ensure patient safety.

52. Taking all of the above into account, the committee is satisfied that by dispensing the controlled drugs and albeit undertaking her own self-check the Registrant failed to ensure the safe dispensing of the drugs.

53. **Particular 2.1 is therefore found proved.**

Particular 2.2

"2. Failed to ensure the safe dispensing of controlled drugs in that you:

2.1 …

2.2 Instructed and / or allowed dispensers to give controlled drugs to patients without the knowledge or supervision of the Responsible Pharmacist on duty at the time."

54. The committee is satisfied that this particular is proved. It reaches this conclusion having considered the following:

a. In her interviews, the Registrant admits that on her days off she left dispensed Controlled Dugs available with the support staff and gave them instructions to give the dispensed medication to patients.
b. In their interviews, the support staff confirm this arrangement.
c. The other pharmacist working at the pharmacy was also interviewed and confirms that they had nothing to do with the medication left by the Registrant for the Support Staff to give to patients.

55. The committee accepts the evidence of Witness 2 that the moment when drugs are handed over by a pharmacy to a patient is a final opportunity to ensure that drugs are being supplied in accordance with a valid prescription and thereby safely. By leaving controlled drugs with support staff to hand-out, without letting them know the drugs were controlled drugs, she thereby circumvented the required final check by a Responsible Pharmacist and thereby failed to ensure the drugs were dispensed safely.

56. **Particular 2.2 is therefore found proved.**

Particular 3:

"3. Failed to report these incidents on the company reporting system (DATIX) in a timely fashion despite being requested to do so."

57. The committee is satisfied that Particular 3 is proved. It reaches this conclusion having taken into account the following.

a. The evidence shows that the Registrant reported the three matters (Patients A, B and C) to the Local Health Board by submitting separate Incident Report Forms for

each patient to the Local Health Board, forms which the Local Health Board uploaded onto it's DATIX incident reporting system.

b. The evidence shows that three days after supplying the Local Health Board with the completed Incident Report Form concerning Patient A, she did, on request, submit it internally on her employer's DATIX system.

c. The evidence shows that she was subsequently asked to submit reports concerning Patients B and C on the employer's DATIX system but that she did not do so.

d. In interview, she referred to believing that the submission of the reports to the Local Health Board's for uploading onto the Health Board's DATIX system meant they were also shared with her employers. The evidence of Witness 1 is that this was not automatically the case and the Registrant learnt this when instructed to submit the reports on the employer's DATIX system. However, when questioned further as to why she had not submitted all the reports onto the employer's DATIX system she is reported as confirming that she had not done so saying: *"I wasn't hiding the information as the LHB had all the information. I just couldn't face it. I knew the LHB would pass information."*

e. When asked in interview whether she had reflected on this issue, she said *"I should have notified them* [her managers] *sooner and didn't realise* [managers] *had already been informed."*

58. The committee is satisfied that she was under an obligation to report to her managers the issues as they arose. This is set out in a company Standard Operating Procedure (SOP) document and reporting would also be a professional responsibility given the seriousness of what was emerging. The relevant company SOP is "SOP 19 Management of Patient Safety". That document refers to Patient Safety Incidents (PSIs) and describes a PSI in the following terms: *"A patient safety incident (PSI) is an error that has affected, or has the potential to affect, a patient or customer's health, and includes errors made in prescribing, dispensing, service delivery or OTC sales/ advice. A PSI is only identified after the patient has received the medication,…"*. Dispensing and then supplying controlled drugs without a prescription would fall within this definition of a PSI. At paragraph 20 the SOP reads: *"Report the PSI on* [the

company] *Datix as soon as possible (the expectation is on the same working day unless there are mitigating factor).”*

59. Taking account of all of the above, the committee is therefore satisfied that by not providing her employer with reports relating to Patient B and Patient C, she failed to report in a timely fashion. The committee is also satisfied that her delay of three days between submitting a report concerning Patient A to the Local Health Board, and subsequently submitting it to her employer, also means she failed to report to the company in a timely fashion. The company only found out when the Local Health Board reported the matter to company managers causing a delay to the employer’s investigations or any opportunity over those three days for the manager to manage the concerns that were emerging.

60. **Particular 3 is therefore found proved.**

61. The committee went on to consider Stage two of these proceedings, namely whether misconduct and impairment are established.

Misconduct and Impairment

62. Having found all particulars of allegation proved, the committee went on to consider whether the particulars found proved amounted to misconduct and, if so, whether the registrant’s fitness to practise is currently impaired.

63. 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:

64. “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."

65. No additional evidence was presented.

66. The committee took into account the submissions made in behalf of the Council.

67. On behalf of the Council, it was submitted that the facts proved amounted to misconduct and that the committee should find the Registrant's fitness to practise impaired on both the personal and public components, and relying on Rule 5 (a), (b) and (c).

68. The committee accepted the advice of the Legal Assessor.

Decision on misconduct

69. The Committee considered whether the Registrant had breached any of the Council's Standards for Pharmacy Professionals (May 2017). The Committee determined that there had been a breach of the Standards, in particular the following:

Standard 1 – Provide person-centred care. By allowing a situation to develop in the Pharmacy whereby patients were supplied Controlled Drugs without a prescription, the Registrant was not making the care of the person her first priority.

Standard 2 – Work in partnership with others. By making arrangements for supply of Controlled Drugs that circumvented the RP on duty when she was not working, the Registrant did not demonstrate effective team working.

Standard 5 – Use professional judgement. By relying on previous entries on the PMR and not using or looking for current valid prescriptions, the Registrant did not have the information she needed to dispense safely and thereby demonstrated poor judgement. Had she exercised professional judgement she would not have relied on out-of-date prescriptions to justify dispensing and supplying controlled drugs to patients, all the more so as time went by.

Standard 6 – Behave in a professional manner. By supplying controlled drugs without a prescription, the Registrant failed to ensure that her actions were in accordance with the law on Controlled Drugs, failed to apply clinical judgement, and demonstrated a lack of professionalism over an extended period of time.

Standard 8 – Speak up when … things go wrong. Although the Registrant did respond to the GP enquiry and co-operated with the local Health Board, she failed to inform the company that she worked for or to make the reports requested of her in a timely fashion.

Standard 9 – Demonstrate leadership. By making inappropriate arrangements with her support staff that in effect circumvented the RP on days when she was not working, the Registrant delegated tasks inappropriately and did not exercise proper oversight.

70. 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).

71. Nonetheless, the committee does conclude that each and all of the facts found proved involved serious departures from the standards expected of her and do amount to misconduct. The committee reached this conclusion taking the breaches of standards and the following into account:

a. The Registrant's supplying of controlled drugs in the absence of a prescription was not in accordance with the law. In interview, the Registrant accepted that she had acted illegally. This alone is serious.

b. Her conduct affected three patients, and for two of them repeatedly over a period of six months also demonstrates the seriousness of her conduct.

c. The nature of the drugs, being controlled drugs capable of causing serious harm, indicates the seriousness of her conduct. These drugs are capable of causing harm if not administered in accordance with a clinical review and monitoring by a

prescriber. In the absence of a current prescriptions, the Registrant could not be assured that the dispensing and supplying of them was not causing harm.

d. The nature of the patients who were vulnerable and deserving of particular care, also demonstrates the seriousness of her conduct.

e. The Registrant's conduct demonstrated a serious failure of clinical judgement. Without a current prescription, the Registrant could not be sure that she was supplying what the patient's healthcare supervisor intended.

f. The Registrant has said that she *"assumed"* there was a current prescription in place when she dispensed the medication while relying on the *"old"* out-of-date prescription and missed multiple opportunities to challenge that assumption and check for a current prescription. In a local arrangement, put in place during the Covid pandemic, the surgery next door would deliver new prescriptions into a *"basket"* at the pharmacy. When asked in interview whether she was managing the basket, she replied *"Wasn't being managed at all which is why this has come about."* When asked why she did not at any point look for a current prescription, she replied *"Snowed under and wasn't able to catch up. Got into a bad habit…".* In interview she acknowledged *"I was never been that good at writing up things in a timely manner"* and *"No excuse from a professional point of view, should have checked"* and *"always on my to do list but always had something pop up, other things got in the way and never caught up"* and she accepted she missed *"daily and weekly"* opportunities to check for current prescriptions.

g. There is evidence that at the time the pharmacy was understaffed and that she was *"struggling"* to complete daily tasks and that the Registrant had raised this with her managers. However, there is no evidence that she escalated the fact that she was acting illegally, cutting corners on patient safety procedures and dispensing controlled drugs without assuring herself that there was a current prescription in place and doing so over many weeks. In interview, the Registrant

said *"Maybe in hindsight should have kicked up more of a fuss about it but was just trying to keep head above water to get through it".*

h. When asked in interview whether her practice of dispensing without a current prescription would still be happening but for the GP surgery realising, the Registrant replied *"Yes* [would have continued] *until volume of work was caught up and I don't know when this would be".*

i. Involving her support staff, albeit they were unaware, also makes her conduct serious.

j. By not informing her employer in a timely way when matters did come to light meant that her employer was delayed in having the opportunity to take action to address patient safety concerns.

72. Taking all of the above into account, the committee is satisfied that each and all of the facts found proved do amount to misconduct. It represented a course of conduct sustained over several months, overall affecting three patients, and persisted in despite the prompts and opportunities there would have been to either check that she actually had prescriptions and/or to fully escalate the situation to her managers, and thereby put patients at risk of harm, albeit no harm was actually suffered.

73. Accordingly, the Committee concluded that, in its judgement, the gateway to impairment of misconduct is established.

74. The Committee therefore did go on to consider whether the Registrant's fitness to practise is impaired.

Decision on Impairment

75. Having found that the particulars of allegation amounted to misconduct, the committee went on to consider whether Registrant's fitness to practise is currently

impaired. In doing so the Committee considered, in line with Rule 5(2) whether the misconduct:

- presents an actual or potential risk to patients or to the public
- has brought, or might bring, the profession of pharmacy into disrepute
- has breached one of the fundamental principles of the profession of pharmacy
- means that the integrity of the registrant can no longer be relied upon.

76. The committee understands that the purpose of fitness to practise proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise as well as to maintain public confidence in the profession and to uphold professional standards.

77. The committee is satisfied that the Registrant's conduct did give rise to a risk to the safety of the three patients. Without a current prescription, the Registrant could not be sure that the dispensing and supplying of controlled drugs was in accordance with a prescriber's clinical supervision of the patient concerned. As set out above, the drugs had the potential to cause harm if not taken in accordance with clinical supervision.

78. The committee is satisfied that the Registrant has demonstrated some insight. However, it cannot be satisfied that in the future she would not cut-corners affecting patient safety if again under pressure. She demonstrated some insight when responding co-operatively and openly with the Local Health Board. In addition, in her interviews with her employers she acknowledged that *"I let standards slip"*, was aware of the potential harm that the drugs could cause, and acknowledged that other pharmacists would be *"shocked"* at what she had done. However, the committee has no current information on what further reflection and training she has undertaken, how she has kept up-to-date with pharmacy practice, nor how she would deal with work pressures in the future, nor how she has addressed what she referred to as having *"never been that good at writing up things in a timely manner"*, which the committee takes to mean an admission that she is not very good at doing basic administration such as filing incoming prescriptions.

79. In these circumstances, the committee is not satisfied that it is highly unlikely she would repeat her misconduct. The committee is satisfied that were she allowed to return to unrestricted practice she currently presents a risk of causing serious harm to patients and her fitness to practise is therefore impaired.

80. The committee is also satisfied that she has brought the profession into disrepute and might do so again given the risk of repetition. Pharmacists are in a position of public trust, trusted as the gate-keepers managing the safe supply of drugs into the community. That role is based on pharmacists being trusted to comply with the law and controlled drugs only being released to patients in accordance with a current prescription. The committee is satisfied that members of the public would be shocked and concerned to know that a pharmacist has acted as the Registrant did. The Registrant's conduct thereby undermines public trust and therefore undermines public confidence in the profession.

81. The committee is therefore satisfied that it should find that the Registrant's fitness to practise is impaired in order to reassure the public that the Registrant's conduct was unacceptable and that a serious view is taken of the Registrant's conduct.

82. The committee is also satisfied that it should find the Registrant's fitness to practise is impaired in order to uphold professional standards. The committee is satisfied that other pharmacists would be appalled at her conduct. The Registrant herself in interview expressed the view that the locum she worked with would be *"shocked".* The message to pharmacists must be that the Registrant's conduct is unacceptable. Pharmacists may well find themselves working under considerable pressure, but the solution is not then to act outside of the law or by cutting corners on basic patient safety procedures.

83. The committee is also satisfied that the Registrant has breached fundamental principles of the profession of pharmacy. It is fundamental that pharmacists act in accordance with the law, particularly with regard to controlled drugs. The Registrant did not do so. It is also fundamental that pharmacists act as the trusted gate-keepers,

controlling the supply of drugs from secure storage into the community in a way that maintains patient and public safety. She did not do this.

84. Finally, it is noted that the Council did not rely on Rule 5(2)(d) (lack of integrity) to establish impairment.

85. The committee anticipated that ordinarily in such a case as this, the Council would allege a lack of integrity on the part of the Registrant but that it has chosen not to do so in the particular circumstances of this case.

86. After careful consideration, the committee agrees with the Council's position in not finding a lack of integrity. The Registrant has identified her own weaknesses as being causes of her conduct, including *"never been that good at writing things up in a timely manner"*, letting other things take priority over checking that prescriptions had been received, and not having *"kicked up more of a fuss"* (concerning the pressure on the branch) when she should have done. However, there is evidence that she was running a branch with on-going staff vacancies and though there may have been some management support to address this, the volume of work appears to have been substantial with the Registrant working extra and unpaid hours. In addition, whilst the Registrant does not make substantial reference to the impact of the Covid 19 pandemic, the first UK Covid 19 pandemic lockdown commenced at around the time that the Registrant's misconduct commenced. In interview, the following exchange occurred:

Q "You mentioned before COVID managing time was a challenge."

A "Yes I reflected on."

Q "At that time, more conscious of?"

A "Yes always been something I'm working on and trying to be better but doubly difficult with COVID".

87. In his evidence, witness 2 accepted that the circumstances of the Covid 19 pandemic could *"possibly have played a part at the start of events"* when there *"could have been short-term disruption"* but not the subsequent extended time over which the

misconduct continued and when the extent of her situation was not escalated. The committee accepts this evidence.

88. The committee's conclusion about integrity is that whilst the Registrant's own weaknesses led to the misconduct this should also be seen against the background of significant pressures, particularly at that time, and that the Registrant's misconduct should be regarded in this context rather than as an act of wilful disobedience to the legal and clinical requirements on her. For these reasons, the committee agrees with the Council's submission that this is not a case whereby the Registrant's integrity can no longer be relied upon.

89. In the light of all the above, the committee does conclude that the Registrant's fitness to practice is currently impaired.

90. The committee was advised that there was no interim order to revoke.

Decision on Sanction

91. Having found impairment, the Committee has gone on to consider the matter of sanction.

92. 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 least restrictive, namely to take no action, to most restrictive, namely removal from the register, in order to identify the appropriate and proportionate sanction that meets the circumstances of the case.

93. 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

in the profession and to promote professional standards. The committee is therefore entitled to give greater weight to the public interest over the Registrant's interests.

94. The committee had regard to the Council's 'Good decision making: Fitness to practise hearings and sanctions guidance' to inform its decision.

95. The committee took into account the submissions made on behalf of the Council. These included submissions on aggravating and mitigating features, and on the options available to the committee.

96. In the Council's submission, the appropriate sanction was one of six months suspension.

97. The committee accepted the advice of the Legal Adviser.

98. The committee first considered what, if any, aggravating and mitigating factors there may be.

99. The committee identified some aggravating factors. The core of this case is that the Registrant dispensed and supplied controlled drugs to patients without a current prescription which was not in accordance with the law and does not meet clinical expectations. The aggravating features include the following:

    a. There were three patients concerned who should be regarded as vulnerable;
    b. The Registrant was regularly and repeatedly dispensing medication and supplying them to these patients without current prescriptions;
    c. This continued over a period of about six months in relation to two of the patients (a shorter period for the third);
    d. The drugs involved were controlled drugs and the supply of the drugs put patients at risk of harm;

e. There were multiple opportunities and prompts when she had the chance to check her assumption that she had current prescriptions. As demonstrated when matters came to light, checking the position was readily achievable but, on her account, she had prioritised other tasks over the need to check;

f. The Registrant was the Branch Manager and therefore in a position of leadership, expected to set an example of good practice;

g. She involved other staff in supplying controlled drugs in circumstances that they should not have done so; and

h. According to her account, her misconduct would have continued for an indeterminate length of time but for the circumstances that led others to investigate.

100. The committee has also identified mitigating features, including the following:

a. She has no previous regulatory adverse findings and there is evidence that she practised as a pharmacist for up to ten years before the events that led to these proceedings;

b. No harm was actually caused to any patient; and

c. When challenged first by the GP, then by the Local Health Board and finally by her employer, she admitted what had happened, proactively checked her records to determine the facts (identifying two of the three patients concerned), recognised the seriousness of what she had done, took complete responsibility, did not try to blame others, demonstrated remorse (she is reported to have been upset during her employer's interview with her), and had started to put into place new systems in the pharmacy to prevent a repeat of what had happened.

101. The committee has also referred above (under the heading 'Impairment') to the evidence that it does not consider her actions to be a wilful disregard of the law and her professional obligations but should be seen against the backdrop of working under pressure. There is evidence she was operating without a full complement of staff and had high-volumes of work. (The committee notes that in an interview with her employer she described how *"On one of the day, pharm plus 1, did 700 Rx, how can we do it?*"). In addition, whilst in her interviews, the Registrant does not refer

significantly to the effects of the pandemic lockdown, and has not attended this hearing to defend her conduct on this basis, the committee notes the coincidence of her failings starting at around the time the first UK pandemic lockdown was introduced when there could have been disruption to normal healthcare services and additional pressures (as evidenced by the witnesses). Nonetheless, the committee cannot ignore that, however her misconduct started, it then continued for about six months, with many missed opportunities to check whether or not there were prescriptions, and without her fully and effectively escalating matters by, in her words, *"kick*[ing] *up more of a fuss".*

102. The committee concludes in this regard that the background to her misconduct enables the committee to conclude that she did not wantonly disregard the rules and procedures, but nor does the background fully explain or excuse what occurred.

103. The committee went on to consider the options available to it, starting with the least restrictive.

104. The committee was satisfied that it would not be appropriate to take no action. To do so would not reflect the seriousness of what occurred and would not protect the public from the risk of harm identified by the committee.

105. The committee was satisfied that it would not be appropriate to administer a warning. To do so would not reflect the seriousness of what occurred and would not protect the public from the risk of harm identified by the committee.

106. The Committee next considered the imposition of conditions of practice. A conditions of practice order would allow the Registrant to practise albeit with restrictions. The Committee must determine whether a conditions of practice order would be appropriate given the concerns identified regarding the Registrant's practice, in particular whether conditions would protect the public from harm, 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.

107. If conditions are to be imposed, the conditions must be relevant and proportionate to the concerns identified regarding the Registrant's practice. Conditions must be workable and susceptible to being monitored. The Committee must also be satisfied that the Registrant will comply with any conditions imposed.

108. The committee concluded that a conditions of practice order was not appropriate in this case. It did so for the following reasons:

a. The committee was not satisfied that a conditions of practice order would adequately reflect the seriousness of the misconduct. The committee has set out above the circumstances that made her misconduct particularly serious, including that it involved a sustained and persistent disregard of the law. The Registrant failed to exercise her clinical judgement in such a way that three patients were put at risk of harm. In these circumstances, a conditions of practice order would not signal to the public or the profession the seriousness of the matter and therefore would not maintain public confidence or operate to uphold professional standards.
b. In any event, a conditions of practice order would not be workable since, at this stage, with a risk of repetition, conditions would need to include such a high degree of supervision that it would not be workable in the work-place.
c. As it is, the Registrant has not engaged with these regulatory proceedings for some while and has not attended the hearing. In these circumstances, the committee cannot be assured that she would comply with conditions of practice.

109. The committee therefore concluded that a conditions of practice order was not appropriate.

110. The Committee next considered whether suspension would be a proportionate sanction. The Committee noted the Council's 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."*

111. The committee gave careful consideration to this option. The committee was concerned by the facts it had found proved and therefore the overall nature of the misconduct as well as the large number of aggravating circumstances it had identified. The committee has also had in mind what it has referred to as the background to the Registrant's misconduct, the fact that no actual harm occurred and her good character.

112. On balance, the committee has concluded that a Suspension Order is an appropriate sanction in this case. The committee is satisfied that a Suspension Order would protect the public by preventing the Registrant from practising at this time. The committee is also satisfied that a Suspension Order of six months reflects the seriousness of the misconduct and is sufficient to send a clear message to both the public and the profession that even when working under pressure, it is not acceptable for a pharmacist to disregard the law or cut-corners on basic procedures that are designed to protect the public and patients from harm.

113. A Suspension Order also provides the Registrant with the opportunity of re-engaging with the process.

114. For the sake of completeness, the committee considered the option of Removal from the Register but concluded at this time that removal would be disproportionate.

115. The committee therefore directs the Registrar to suspend the name of Rebecca Faye Platt (registration number 2073233) from the register for a period of 6 months from the date that this order comes into effect.

Review Hearing

116. This decision will be reviewed by the committee before the sanction expires. It is a matter for the Registrant what, if any, evidence she provides to the committee at a review hearing. However, the committee may be assisted by:

a. Evidence of CPD and how she has maintained her skills as a pharmacist.
b. Evidence of what training she may have undertaken to address the issues that arise in this case, including for example concerning the handling of controlled drugs, the treatment of addicts, leadership and assertiveness;
c. References from any voluntary or paid work she has undertaken;
d. Any testimonials she may wish to submit; and
e. A written reflective piece by the Registrant.

117. The committee emphasises that it is for the Registrant to decide what of any evidence she wishes placed before a review hearing and it will be for the committee on that occasion to assess the impact such evidence may have on its assessment of her fitness to practice.

Interim Measure

118. The order of suspension that the committee has imposed does not come into effect immediately. It comes into effect at the conclusion of an appeal period if there is no appeal lodged, or if there is an appeal at the conclusion of the appeal proceedings.

119. On behalf of the Council, an application was made for an Interim Measure of suspension to cover the appeal period and the period of any subsequent appeal proceedings. The application was based on the findings of the committee set out above particularly with regard to future risk of harm to the public.

120. The committee received and accepted the advice of the Legal Assessor.

121. The committee determined to grant the application. It had in mind the 'Good Decision Making Guidance'. It grants the Interim Measure on the basis that it is necessary for the protection of the public and that it is otherwise in the public interest. The committee relies on its earlier findings, in particular having regard to future risk of harm to the public of a repetition of the misconduct and given the seriousness of what has occurred. The committee is satisfied that an Interim Measure of conditions of practice would not be appropriate or proportionate for the reasons previously given, in particular the lack of current engagement from the Registrant. The Interim Measure will therefore be of suspension. This takes effect immediately and covers the period during which the Registrant may appeal against the committee's decisions and the period of any appeal proceedings that may then follow.

122. Accordingly, the committee orders that an Interim Measure of suspension is imposed on the Registrant.

123. This concludes the determination.