General Pharmaceutical Council

Fitness to Practise Committee

Principal Review Hearing

General Pharmaceutical Council, Level 14, One Cabot Square, Canary Wharf, E14 4QJ

5 September 2023

Registrant name:	Abbas Ul Hassan Samnani
Registration number:	2084418
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Philip Geering (Chair) Stephen Simbler (Registrant member) Isobel Leaviss (Lay member)
Legal Adviser:	Ralph Shipway
Secretary:	Gemma Staplehurst
Registrant:	Present and represented by Martin Hadley, VHS Fletchers
General Pharmaceutical Council:	Represented by Jamila Bernard-Stevenson, Case Presenter
Order being reviewed:	Suspension (9 months)
Fitness to practise:	Not impaired
Outcome:	Order to lapse on expiry, (midnight, 16 September 2023)

DETERMINATION

Introduction

1. This is the written determination of the Fitness to Practise Committee ('the committee') at the General Pharmaceutical Council ('the Council'). It is the determination of the Committee at a review of a substantive order.

2. The subject of the hearing is Mr Abbas Ul Hassan Samnani ('the Registrant') who is registered with the Council as a Pharmacist, registration number 2084418.

3. In November 2022, the Registrant was subject to a Principal Hearing before the committee. The Registrant faced an allegation that his fitness to practise was impaired by reason of misconduct.

4. The allegation was as follows:

"You, a registered pharmacist:
1. You worked as a locum pharmacist at St Mary's Hospital, Isle of Wight NHS Trust ("the Trust").
2. You caused, allowed and/or permitted time sheets to be completed with false information, in that you represented to the Trust that you had worked more hours than you had worked, on one or more of the dates as set out in Schedule A (attached).
3. You actions at paragraph 2 were dishonest in that:
3.1. You did not work for all of the time for which you claimed you did on your time sheets;
3.2. You knew you did not work for all of the time for which you claimed;
3.3. You intended to mislead any individual(s) reviewing the timesheets into believing you had worked the time for which you claimed in order to obtain payment.
By reason of the matters set out above, your fitness to practise is impaired by

reason of your misconduct."

5. Schedule A, referred to in the allegation, listed thirty separate dates ranging from 8 November 2018 to 1 August 2019 being his weekly timesheets.

6. The Registrant admitted the factual particulars which were therefore found proved. He also admitted misconduct. The committee found misconduct and also that his fitness to practise was impairment by reason of that misconduct.

7. The committee imposed a sanction. The Registrant was made subject to an Order of Suspension from the Register for a period of 9 months. The order will expire at midnight on 16 September 2023.

8. That Committee directed that the sanction should be subject to review.

9. This is the first review of that sanction.

10. The review 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").

11. 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.

12. 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.

(See Article 6 of the Order as amended).

Service of Notice

13. The committee has seen a letter dated 24 July 2023 from the Council headed 'Notice of Hearing' addressed to the Registrant giving details of when and how this hearing would be held, which at that time included the hearing being held remotely. The Registrant made an application for the hearing to be held in person. That application was granted and, as a result, a revised Notice of Hearing was issued.

14. No issue was taken by the parties with regard to service.

15. The committee was satisfied that there had been good service of the Notice.

Documentary Material:

16. The Committee was provided with the following documentary material.
    a. A bundle provided by the Council indexed and paginated to 1 to 96 pages.
    b. Combined Case Statement and Skeleton Argument for the Council dated 1 September 2023.
    c. A bundle provided by the Registrant containing a statement by him signed and dated 5 September 2023 with an indexed bundle of documentary exhibits paginated to page 45.
    d. Skeleton Argument submitted on behalf of the Registrant dated 4 September 2023.

Proceedings in Private:

17. An application was made on behalf of the Registrant for parts of the hearing to be held in private when concerning the details of the health of his family members. This was not opposed by the Council.

18. The committee received and accepted the advice of the Legal Adviser.

19. The committee granted the application.

This Review: powers of the committee.

20. To conduct a review the committee must review the concerns raised in the original finding of impairment, determine whether or not the Registrant's fitness to practise remains currently impaired, and, if so what if any sanction to impose. In practical terms there is a persuasive burden on the Registrant to show that his fitness to practise is no longer impaired or, if currently impaired that either a lesser sanction should be ordered or no action taken.

21. The powers of the Committee on a review are wide. They are set out in Article 54(3)(b) of the Order. They include the power to remove the Registrant's name from the Register, to extend the period of suspension, to impose conditions on the Registrant's registration. In addition, the committee may make no further order meaning that the current order would come to an end on its expiry date.

Background

22. The background circumstances of this case are as follows.

23. The Registrant worked as a locum pharmacist at St Mary's Hospital on the Isle of Wight through a locum agency, although he continued to live in Stockport, Manchester. The Registrant worked at St Mary's Monday through to Thursday and would return home following his working day on a Thursday. Each week he would

complete a timesheet recording his time worked over the days worked that week. The timesheets were submitted to the locum agency so that he would be paid. The timesheets contained a declaration as to the accuracy of the information given.

24. Concerns were raised that the Registrant had falsified timesheets which had recorded his working hours, in so far that he had been leaving earlier than declared on a Thursday.

25. There was evidence that he had falsified the weekly timesheets on 30 separate occasions between 8 November 2018 and 1 August 2019 – a period of 39 weeks. Some of the discrepancies were for significant lengths of time. For example, his timesheet for 4 July 2019 records him working until 1pm when it is calculated that he in fact left at around 9:30am. The concerns were identified when there were a number of occasions when colleagues, needing the Registrant's assistance, could not find him on the hospital ward where he was expected to be or contact him on his mobile phone and bleeper. Two occasions were identified when he had not logged onto the Electronic Prescribing and Medicines Administration system at all, which was regarded as unusual given that his work was predominantly ward-based.

26. It was calculated that the Registrant had been overpaid by £3,440.30 between November 2018 and August 2019 (approximately 65 hours worked). This amount had been re-paid by the Registrant to the relevant NHS Trust some considerable time before the Principal Hearing taking place.

27. During the investigation of these concerns the Registrant referred to occasions when he had*, "on occasions"* worked longer that scheduled and had been unpaid. The committee at the Principal Hearing concluded that there was *"no independent evidence before us to show that the Registrant would routinely work beyond 8pm, had worked an additional 64.5 hours (the number of hours which the Registrant claimed for on his timesheets when in fact he was travelling home) or was often told to leave early to make up for the extra hours he had worked*" as he had claimed.

28. He stated that *"my motivation to finish early was only to get back home to help relieve my father of his duties caring for my mother"* and he provided evidence relating to the health of his parents. He subsequently provided a statement that he had got into a pattern of completing his timesheets *"without much thought"* save to ensure that the timesheets reflected his contracted hours and he accepted that he did not know the actual hours he had worked. At the time of the Principal Hearing, he accepted that *"I knew that I had not worked those times and my acts were dishonest"* and referred to his *"feelings of entitlement driving my now recognised dishonest actions".*

29. At the Principal Hearing, the Registrant formally admitted the factual particulars of the allegation which were therefore found proved.

The Principal Hearing

30. The committee at the Principal Hearing concluded that his behaviour fell seriously below the standards of the profession, that he had misconducted himself and that his fitness to practise was impaired.

31. In reaching these conclusions, the committee also found as follows:

    a. That his misconduct involved a breached trust by defrauding the public purse and *"was a pattern of behaviour which is likely to have continued had the Registrant not been caught."*
    b. That the Registrant had provided a 'shifting narrative' through the various accounts he had provided during the NHS investigations and the Council's investigation and proceedings.
    c. The committee further highlighted that the Registrant had only acknowledged that his actions were dishonest in his statement prepared for the Principal Hearing.

d. That despite having three years to reflect, the Registrant's insight appeared limited and that his written reflection pieces were somewhat generic in their nature. The committee was in particular concerned that even after the passage of time he was only prepared to accept on a very limited basis that patients "may" have been impacted by his misconduct or impacted on his colleagues. He only accepted *"dishonesty"* at the time of the hearing and not before.
e. The committee was concerned that whilst he had told the main agency he was registered with, he had not told other employers about the proceedings, which was indicative of not being open and honest in a way that went to his lack of integrity.
f. The committee was also concerned that the proposed steps the Registrant had offered in remediation appeared to have limited practical effectiveness, which included a table he designed shortly before the hearing for him to record his working times, but which he had not yet actually used and which, in any event, the committee concluded only another form of timesheet.
g. That the Registrant's motivation for leaving work early was not greed, but rather that he was worried about his parents and wanted to get home to relieve his father from his caring responsibilities.
h. That he was otherwise a highly competent and well thought of pharmacist.
i. However, *"*[T]*he Registrant's integrity cannot be relied upon at this time. This was not an isolated incident, but repeated dishonesty involving defrauding the NHS. His acceptance of his dishonesty has only come about very recently. We consider that the Registrant always knew that what he was doing was dishonest."*
j. That his misconduct gave rise to a risk to patient safety.
k. That there was a risk of repetition and therefore a need for a finding of impairment.
l. That there should also be a finding of impairment to maintain public confidence and to uphold professional standards.
m. When considering sanction, the committee took into account a number of aggravating and mitigating features.

32. Having imposed the sanction of a 9-month suspension order, the committee at the Principal Hearing went on to direct that there should be a review hearing. In doing so, the committee observed as follows:

> *"However, he should not take it for granted that he will be able to resume practice in nine months' time - the reviewing committee will need to be satisfied that he has developed sufficient insight and remediation so that the risk of repetition has been lowered significantly.*
>
> *…. Although we cannot bind any future Committee, the Reviewing Committee may be assisted by:*
>
> - *further written reflection from the Registrant to fully demonstrate his understanding of the misconduct, and the impact this had on his colleagues and patients*
> - *Evidence that the Registrant has undertaken a course of Probity and Ethics*
> - *Evidence that the Registrant has robust strategies in place so that he is able to appropriately balance his professional and family responsibilities*
> - *The Registrant's attendance at the review hearing"*

This Review Hearing

33. In addition to the documentary material set out above, the Registrant gave oral evidence on oath and was questioned by the committee.

34. The Registrant's written and oral evidence included evidence of him undertaking reflective practice, undertaking mentoring, peer review, CPD including courses specifically on ethics, probity and professionalism, of him seeking and eventually obtaining work allied to healthcare. He gave evidence of being open with others

about his suspension for dishonesty and his expressed determination to recover his professionalism. It also included a number of references.

35. The Council's evidence includes statement from a member of Council staff responsible for monitoring the Registrant's compliance with the suspension order. The statement concludes that the Council *"has received no concerns to suggest that the Registrant has been working as a registered pharmacist whilst his registration has been suspended."*

36. On behalf of the Council, it was submitted that the Council adopted a *"neutral"* stance on the issue of impairment and, if relevant, on sanction, referring only to the relevant legislation and guidance.

37. On behalf of the Registrant, it was submitted that the Registrant had now remediated his impairment and that the committee should find his fitness to practise no longer impaired. It was further submitted that if the committee finds his fitness to practise to be still impaired, the committee should consider a sanction of Conditions of Practise.

38. The committee received and accepted the advice of the Legal Adviser.

39. The Committee reminds itself that it is for the committee to determine whether or not the Registrant's fitness to practise is currently impaired. The committee also notes that the burden is on the Registrant to persuade the committee that it is not.

The Committee's Decision and Reasons at this Review

40. The committee has determined that the Registrant's fitness to practise is no longer impaired. It does so for the following reasons.

41. The committee at the Principal Hearing had been referred to a letter the Registrant had sent the hospital in 2020 to apologise for his conduct. The committee at that

time did not have a copy of that letter. The committee has been provided with a copy of that letter for today's hearing. It is dated 10 July 2020. It shows that at that time the Registrant accepted he had done wrong, that he *"broke your trust"* and "*fell short of standards"*. As with the Principal Hearing, the letter was limited on acknowledging the impact on patients and his colleagues. However, the committee accepts, as did the committee at the Principal Hearing, that he had commenced a journey towards having developed insight on his misconduct.

42. The committee at this Review Hearing accepts that he has now substantially progressed with that journey and that he now has sufficient insight into his misconduct to understand that he is responsible, the seriousness of what he did, the reasons why his misconduct came about, the impact it has had and what he needs to do to avoid repeating it.

43. The committee is satisfied that he now sufficiently understands the impact of his dishonesty on patients. He gave oral evidence describing how hospitals are "dynamic" places, that the circumstances of patients and on wards can change, and that by absenting himself from the hospital he would not have been able to fulfil his duties and that this impacts on patients. He spoke about the possibility that this may delay the discharge of patients, who could then be disadvantaged by remaining in hospital overnight, that this would then create a "bed-blocking" issue that would mean new patients would then be delayed from being admitted to the ward for care. He also apologised to patients that he had not been able to serve whilst he had been suspended for his misconduct.

44. The committee also accepts that he now sufficiently understands the impact his misconduct had on his colleagues. He spoke about how they would have had to waste time looking for him, and who would have been caused difficulties by not being able to obtain his advice. He spoke about the nature of teamwork within the hospital, that it is like a system and that if one part of the system is at fault as he was then the whole system can be impacted. He spoke about his work with StreetCars, an organisation that arranges transportation of patients between home and hospital

and back. He gave evidence that he had told StreetCar about the finding of dishonesty and his suspension, an account which is supported by the reference from the manager at StreetCar. He described how it was important for him to be reliable and on time, and that if he was late delivering a patient to hospital, it would delay that patient's care, and disrupt the schedule for other patients and clinicians. He accepted that his response at the time of the Principal Hearing that colleagues could have contacted him by WhatsApp was wrong.

45. In relation to both the impact on patients and the impact on colleagues, he described how a failure by can lead to a *"chain reaction"* that can impact adversely on others. The committee was satisfied that this was evidence in support of him now understanding about the impact of his behaviour on others.

46. He also recognised the impact on trust in the profession. He spoke about an incident when a patient he was driving to and from hospital opened up to him about the issues he, the patient, was facing after he, the Registrant, had disclosed that he was a pharmacist who had been suspended. He gave evidence that this incident brought home to him the trust and confidence the public have in healthcare professionals, how that enables care to be given and the importance of maintaining that trust.

47. He gave written and oral evidence about how, following the Principal Hearing, he had had a family meeting with his brothers when, despite a cultural expectation, it was discussed that he could not, as had been the case, take the greater burden of caring for their mother and that the care would have to be shared. His evidence was that this was accepted by his brothers, and that they now have better communications between themselves. He gave written and oral evidence of how they now have a rota in place to share caring responsibilities. He also gave written and oral evidence describing how they have arranged for paid care to be in place for their mother, and described the brothers and the paid carers as *"a team"* who shared being "on duty". The committee accepted that he had taken substantial steps to have in place a balanced means of meeting his caring responsibilities.

48. The Registrant also gave evidence of how he now has an app that logs his timings and locations, which he has used to accurately record his working time: when he starts work, has breaks from work, and when he finishes work. His evidence is that he can share the information from this app with a superviser who needs a timesheet. The committee found that the significance of this evidence is in the diligence he is now showing in keeping a record rather than the actual form of the record. At the time of his misconduct, the evidence demonstrated a lackadaisical approach whereas his evidence at this time demonstrates a commitment to accurately and adequately recording times.

49. The committee gives the Registrant credit for the monthly reflective diary he has kept since being suspended. It underscores the evidence of him being on a journey to gain insight over time, a journey the committee is satisfied he has continued since being suspended. It is clear from the diary that the Registrant struggled initially with being suspended but has steadily worked over the period of his suspension to systematically address the specific issues that arose. The Registrant gave evidence of engaging with a Mentor, AC, a pharmacist who he has known since 2014 with whom he has undertaken periodic discussions and that he intends to continue to do so. The Registrant gave evidence that in the weeks after being suspended he was not in a position to satisfactorily and clearly think about the issues or digest the detail of the Principal Hearing determination. He describes recognising that he needed someone else to help him and he turned to AC. He gave evidence that AC read the determination and helped him to identify specific issues that he was then able to use for his seven individual reflective pieces in which he describes the issues, the impact and how he was addressing each issue. The committee gives him credit for recognising that he needed to talk with someone else, that he received and accepted their advice, and followed through by producing the detailed and structured reflective pieces that he has provided to this committee.

50. The Registrant gave evidence that through his patient-driving work he has come into contact with former colleagues who knew him as a pharmacist. His evidence is that he has been open with them about his dishonesty and suspension. He gave evidence

that this was difficult to do but accepted that it was the right thing to do if he wanted to regain the trust of colleagues. The papers provided on his behalf include a reference from EB, a registered nurse, who states that having coincidently met him in work, they agreed to meet up, and that when they did "He was very quickly open and honest about his situation…that he had been dishonest…and had rightfully suspended for his unacceptable actions." The committee accepts that he has, since being suspended, been open with others about both his dishonesty and the suspension. The Registrant's evidence is that he now understands that this is how he should be. The Registrant gave evidence about how he and EB have undertaken peer review work and are committed to continuing to do so.

51. During questions from the committee, it was put to the Registrant that difficulties and challenges of different sorts may arise in the future that he will have to deal with. Mistakes can also be made that need to be dealt with. The question for him was how he would deal with things in the future. The Registrant spoke clearly about the need for *"openness and honesty and accountability"*, the importance of sharing things with others, knowing that people can more easily forgive things if they are disclosed. He acknowledged that there could be pressures on him in the future when he would have to balance work and personal life, and that in future he would be honest and open with supervisors to deal with issues. He spoke of when mistakes may happen, for example, in issuing a prescription, and that he would be 'open and honest and accountable', would complete an Incident Report form, so the matter could be dealt with, and that by being open 'we can learn from one another'.

52. The Registrant gave evidence that he hopes to return to practise and that he had maintained his CPD in order to do so.

53. The committee is clear that matters of dishonesty by professionals are to be taken extremely seriously. Professionals who are dishonest, even in one respect of their lives not connected with their clinical practice, risk undermining trust in them and public confidence in the profession which can be hard to recover. In turn this can

lead to members of the public potentially coming to harm by not seeking or receiving the care and treatment they need. A finding of dishonesty is difficult to remediate.

54. However, in this case, the committee takes account of the nature of the dishonesty, which, whilst it was deliberate and repeated over time, was not motivated by greed but by the Registrant's failure to balance his work and personal life.

55. The committee also notes that whereas the committee at the Principal Hearing noted his "shifting narrative", his written and oral evidence to the committee at this Review Hearing has been cogent and consistent, demonstrating his improved level of insight.

56. The committee is satisfied, having taken all of the above into account, that the Registrant does now have insight on his misconduct in the way that is described above. The committee is satisfied that he has learnt from this experience. He has strategies in place to deal with the immediate issue concerning his mother's care. More importantly, he has strategies for dealing with challenges in the future, including an attitude of being open, honest and accountable, and including by having a professional support network to whom he can turn which he plans to sustain. The committee is satisfied that his integrity can now be relied upon.

57. The committee concludes that the risk of repetition is minimal and that therefore the risk of patient harm in the future is low.

58. The committee is satisfied that the process of these regulatory proceedings, the findings against the Registrant, and the sanction of nine-month's suspension meets the wider public interest in this case. The public can be assured that dishonesty by pharmacy professionals is not acceptable and will be addressed, and that public confidence can be thereby maintained. The message to pharmacy professionals is that dishonesty is not acceptable, that they are required to be open and honest and accountable especially when faced with challenges or when things go wrong.

59. In the light of these findings, the committee is satisfied that the Registrant's fitness to practise is no longer impaired and that he may return to unrestricted practise at the expiry of the suspension. The committee notes that the evidence is that his clinical skills as a pharmacist were not in question.

60. The committee was satisfied that this fitness to practise proceedings have been an adequate response to the Registrant's misconduct and that this was not a case when Advice or a Warning was required.

61. This concludes the determination.