**General Pharmaceutical Council**

**Fitness to Practise Committee**

**Principal Hearing**

Remote videolink hearing

**11-13 September 2023**

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| **Registrant name:** | Paresh Gordhanbhai Patel |
| **Registration number:** | 2043480 |
| **Part of the register:** | Pharmacist |
| **Type of Case:** | Misconduct |
| **Committee Members:** | David Bleiman (Chair)<br>Surinder Bassan (Registrant member)<br>Stephen Greep (Lay member) |
| **Legal Adviser:** | Anand Beharrylal KC |
| **Committee Secretary:** | Gemma Staplehurst |
| **Registrant:** | Present & represented by Daniel Lister,<br>23 Essex Street |
| **General Pharmaceutical Council:** | Represented by Deborah Tompkinson,<br>33 Bedford Row |
| **Facts proved by admission:** | All |
| **Fitness to practise:** | Impaired |
| **Outcome:** | Warning |

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 12 October 2023 or, if an appeal is lodged, once that appeal has been concluded.

**Particulars of Allegation (as amended)**

*You, a registered pharmacist:*

*Whilst working as a locum pharmacist and Responsible Pharmacist at Crompton Pharmacy, Whitley House Surgery, Chelmsford ('the Pharmacy');*

*1 On, or around, 11 and 12 November 2019:*

*(a) Dispensed, or allowed to be dispensed, 56 tablets of 120mg Oxycodone Hydrochloride rather than the correct prescription of 56 tablets of 20mg Oxycodone Hydrochloride for Patient A's use;*

*(b) Supplied, or allowed to be supplied, 56 tablets of 120mg Oxycodone Hydrochloride rather than the correct prescription of 56 tablets of 20mg Oxycodone Hydrochloride for Patient A's; and*

*(c) When questioned by Witness 1 regarding the Oxycodone Hydrochloride tablets, failed to carry out any or sufficient checks to ensure the tablets you had dispensed and/or supplied to her were in accordance with the relevant prescription.*

*2. As a result of your conduct at paragraph 1, Patient A suffered an overdose of Oxycodone Hydrochloride, which contributed to her death.*

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

**Documentation**

Document 1- GPhC hearing bundle (90 pages), replacement (legible) copy of p.44

Document 2- GPhC skeleton argument (17 pages)

Document 3- Registrant's bundle (81 pages)

Document 4- Statement read by Mr Patel at hearing on 13 September 2023 (1 page)

**Witness statements produced**

Witness 1 - daughter of Patient A

Witness 2 - Patient A's GP

Witness 3 - Pharmacy Assistant

Witness 4 - Superintendent Pharmacist

Paresh Patel, Registrant

Three testimonials for Mr Patel

## 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* ("the 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.

**Amendment of allegations**

6. The Committee, of its own motion, having heard from the parties and accepted legal advice in relation to Rule 41(1), amended the allegations so as to correct a typo. In allegation 2 the reference to "paragraph 2" in line one, is to read "paragraph 1".

**Facts found proved by admission**

7. Mr Patel admitted all the allegations as particularised in allegations 1 and 2 above.

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

9. We went on to consider whether Mr Patel's fitness to practice is currently impaired which is a matter for the Committee's judgement.

**Agreed background facts**

10. The parties supplied a statement of "agreed facts" which we provide in full:

(1) The registrant was registered on 17th July 1995.

(2) He worked as a locum pharmacist through PharmAssist and Capital locums from July 1995 to August 2006.

(3) From August 2006 to 2013, he worked as Superintendent Pharmacist Director with Audley Mills Pharmacy in Southend on Sea.

(4) From 2013 to 2018, the Registrant did locum work through Locate A Locum.

(5) From 2018 to October 2020, the Registrant worked as a Superintendent Pharmacist with PeoplesChemist.co.uk Southend on Sea, an on-line pharmacy which he owned (and is now closed). His hours in this business were 08:00-13:00 and 14:00 -17:00 each day.

(6) From May 2019 to March 2020 the Registrant worked as a locum pharmacist at Crompton Pharmacy. His hours at Crompton Pharmacy at the material time, were

(i) from 18.00 to 22.30 Tuesday, Wednesday and Thursday (*4 ½ hours*), and

(ii) from 07.00 to 22.30 on Saturdays (*15 ½ hours*) and

(iii) from 10.00 to 17.00 on Sundays (*7 hours*).

(7) The Crompton Pharmacy was short staffed because of a combination of circumstances. Although the Registrant did not normally work during the day as a locum, he agreed to do so on Monday 11 November 2019. He stepped in because the usual pharmacist had suffered a bereavement. He did not, at that time, intend to work the next day, Tuesday, 12th November 2019.

(8) On the evening of 11 November 2019, he labelled a prescription for Patient A, an elderly lady, for 56 tablets of Oxycodone, a controlled drug ("CD"). Oxycodone was for 12 hour modified release.

(9) The Registrant made an error in the dispense of the said Oxycodone tablets. He prepared a label and ordered stock for 56 tablets of 120 (one hundred and

twenty) mg of Oxycodone 12 hour modified release instead of the prescribed 56 tablets of 20 (twenty) mg of Oxycodone 12 hour modified release. It follows that the tablets ordered were 6 times stronger than those prescribed. See the photograph of the packet of pills, patient pharmacy record, and prescription. [The Committee has viewed these documents.]

(a) The Registrant admitted to the Coroner's inquest that he made a mistake in preparing the label.

(b) In answer to questions from the family, he explained that the strength 120 mg was supplied by a drop down box in the computer system, which he said highlighted 120 mg to input instead of 20mg.

(c) He also said he was not sure whether he read it as 20 or 120 or whether he inadvertently pressed the 1 and 2 keys together, then the 0 key.

(10) The next morning, 12 November 2019, the Registrant was asked to attend Crompton Pharmacy again, because the locum who had been booked did not attend. He arrived at 13.00 after the deliveries of CDs had taken place. The other member of staff was a trainee dispenser who could not check CD prescriptions. Accordingly, the Registrant undertook this task and entered the CDs in the CD register.

(11) When Witness 1 arrived, the Registrant recalled the 120 mg Oxycodone order he had labelled the previous day. Witness 3 informed him she was not allowed to check any CD prescriptions. The Registrant retrieved the stock from the CD cabinet and attached the label checking he had the 120 mg box. The dosage was correct. He did not spot the original error regarding the strength.

(12) He bagged it and handed it to Witness 1.

(13) At some point (whether in the pharmacy or in a telephone call afterwards) Witness 1 raised a query about the dispense. The exact words she used are not agreed. The Registrant checked the patient medical record.

(14) The terms of his response are not agreed.

(15) Patient A died of overdose of Oxycodone after taking one tablet. The record of inquest concludes '*Deceased dies as a result of an accidental overdose of oxycodone. This was the result of a dispensing error of her prescribed medication. Serious natural disease also contributed to her death.'*

(16) Her death resulted from the Registrant's mistake.

(17) The Registrant immediately admitted that he erred to Crompton Pharmacy and again at the Coroner's inquest. At the Inquest, he apologized to family and expressed his sorrow for their loss and for his involvement in the dispensing error.

(18) The Registrant, in his statement to the Coroner, attributed his error to tiredness, fatigue, stress and shortage of staffing, such that the CDs could not be double checked by 2 persons.

**Misconduct and Impairment**

11. Having found all of the particulars of the 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.

12. At the outset of this stage of the hearing, we dealt with a number of preliminary matters.

**Factual matters not agreed**

13. Having heard from the parties and accepted legal advice, we determined that the background facts which remained in contention, as noted at paras (13) and (14) of the agreed statement of facts, were not material to the misconduct, impairment (and potentially sanction) stages of this hearing. We did not need to resolve these factual differences and therefore did not need to consider evidence or submissions as to these matters.

**Concession of impairment of fitness to practise**

14. Mr Lister informed us that Mr Patel, who had already conceded that his actions amounted to misconduct, now wished also to concede that this fitness to practise is impaired as he concedes that he has breached one of the fundamental principles of the pharmacy profession.

15. It is for the Committee to exercise our own judgement as to whether Mr Patel has committed misconduct and, if so, whether his fitness to practise is currently impaired. However, his concession was relevant in relation to further preliminary matters before us.

**Whether to admit evidence of Witness 4**

16. Ms Tompkinson had indicated an intention of calling Witness 4 to give evidence on procedures within the Crompton Pharmacy regarding ordering of medications, amending the PMR, printing labels and dispensing. Following the concession regarding impairment, she was not able to say whether she would wish to call the witness and, for reasons of expedition, rather than adjourning for her to take instructions, we proceeded on the basis that she might wish to call the witness.

17. Mr Lister opposed the admission of oral evidence on the matters noted above as these had not been included in the witness statement and there would be potential unfairness to Mr Patel in having to respond to matters of which he had not had notice.

18. We accepted legal advice. We determined that Witness 4 should not be heard on the new matters raised by Ms Tompkinson. This would be unfair to Mr Patel, as the matters were not contained in either of the witness statements from Witness 4. In any event, in the light of admission to all the allegations and the concession by Mr Patel in relation to both misconduct and impairment, we did not consider that it would be of assistance to the Committee to hear further detail regarding procedures within the Crompton pharmacy.

**Adjournment for consideration of potential undertakings**

19. Mr Lister applied for an adjournment to allow him to finalise proposed undertakings which Mr Patel wished to put forward as a suitable disposal of the case, following Mr Patel's admission of impairment. Ms Tompkinson indicated that she would require to take instructions, once the proposals were available.

20. We accepted legal advice and agreed to allow an adjournment until 3pm on the first day of the hearing. We took into account that it was now clear that the Council would not be calling witnesses, that Mr Patel had now conceded both misconduct and impairment and that, in consequence, the public interest in the expeditious disposal of the case was unlikely to be prejudiced by an adjournment. It would be fair to the parties to allow Mr Lister to finalise Mr Patel's proposed undertakings and for Ms Tompkinson to take instructions on the matter.

21. On resuming, we heard that, in the light of the Council's view of the matter, Mr Lister would not be pursuing the proposal for undertakings at this stage.

**Submissions on misconduct and impairment**

22. We proceeded with hearing submissions as regards misconduct and impairment. The parties did not call any evidence at this stage of the hearing.

**Submissions for the Council**

23. Ms Tompkinson submitted that Mr Patel's actions amounted to a series of negligent acts or omissions which amounted to an elementary and grievous failure and a falling short of the standards ordinarily required. She pointed out that Mr Patel had had several opportunities to retrieve his mistake. In the alternative, she submitted that, if this was to be regarded as a single act or omission, it was particularly grave so as to amount to misconduct.

24. Ms Tompkinson submitted that Mr Patel's conduct involved a breach of the Council's *Standards for pharmacy professionals*, May 2017 ("the Standards"), referring in particular to Standards 1, 3 and 5. She highlighted also the overall objective of the Standards to deliver "safe and effective care". She submitted that Mr Patel had been working excessive hours (running his own online pharmacy as well as working as a locum). He had failed to recognise that he should not be working while admitting that he was suffering from tiredness and stress. By checking his own dispense in the absence of a second checker, he had failed to exercise his professional judgement. He failure to notice the discrepancy between the prescribed strength of medication and that which he ordered and dispensed was, she submitted, a failure of professional

judgement. His communication skills in his conversation with Witness 1 had been lacking.

25. Ms Tompkinson accepted that Mr Patel did not intend any harm to Patient A, was trying not to let down patients or the Crompton pharmacy and that he had immediately admitted responsibility, apologised and was clearly remorseful for the consequences of his errors.

26. In relation to impairment, Ms Tompkinson submitted that Mr Patel's conduct engaged Rule 5 (2) (a), (b) and (c).

27. *Rule 5 (2) (a).* Ms Tompkinson accepted that Mr Patel had shown "some limited insight", was remorseful and that there was "some evidence of reflection". However, she pointed to a lack of insight into what she described as "underlying attitudinal failures" which had led to his communication failures and tiredness and what she described as an "over-conscientious" willingness to work at a time/in an environment when he should have recognised that it was not safe to do so. He had closed his online pharmacy business after the death of Patient A but it had taken him nearly a year to do so, for reasons which had not been explained. She submitted that Mr Patel currently presents an actual or potential risk to patients.

28. *Rule 5 (2) (b).* Ms Tompkinson submitted that the avoidable death of a patient because a pharmacist misread a prescription and did not discover the mistake despite several opportunities to do so, had brought the pharmacy profession into disrepute. The profession might be brought into disrepute were a finding of impairment not to be made in such circumstances.

29. *Rule 5 (2) (c).* Ms Tompkinson reiterated her submission as regards breaches of the Standards in relation to misconduct.

**Legal advice regarding drawing of inferences**

30. In the course of her submissions, Ms Tompkinson had invited us to draw inferences from aspects of Mr Patel's witness statement and the record of the Coroner's inquest. We invited and accepted legal advice on the matter. We accepted that we should only draw an inference from an unequivocal fact from which it would be safe to do so. We should not enter into speculation.

**Submissions for Mr Patel**

31. Mr Lister reminded us that Mr Patel conceded misconduct and impairment of his fitness to practise.

32. As regards misconduct, Mr Patel admitted to a series of errors and that he should have behaved differently on 11 and 12 November 2019. We were however invited to bear in mind the circumstances, which included a bereavement suffered by Witness 4 and the poor staffing levels in the Crompton pharmacy. This was a situation in which Mr Patel felt a compulsion, at a human level, to assist.

33. Mr Lister accepted that Mr Patel had breached Standards 1, 3 and 5 of the Standards.

34. Impairment was accepted but only on grounds of a breach of fundamental principles of the profession.

35. *5 (2) (a).* Mr Lister said that the events in 2019 occurred in the context of no other incidents in the previous 24 years of registration and of Mr Patel working safely for nearly 4 years since the incident with no interim restrictions on his practice. Mr Lister referred to evidence of reflection in Mr Patel's witness statement.

36. Mr Lister submitted that we could not properly draw an inference that, contrary to his own evidence, Mr Patel knew in advance that the trainee dispenser was not authorised to check CDs. He submitted that it had taken some time to close his online pharmacy business but, as regards future risk, the position now was that he was no longer working excess hours.

37. Mr Lister submitted that Mr Patel had shown insight by accepting his mistake at a very early stage and at the Coroner's inquest. He now conceded both misconduct and impairment. By drawing attention to factual circumstances including understaffing of the Crompton pharmacy, he was not attempting to shift blame. He had shown insight into his own failure to follow procedures and identified what he would do differently in the future.

38. Mr Lister submitted that Mr Patel had shown remorse and apologised direct to Witness 1 at the inquest.

39. In relation to remediation, Mr Lister submitted that Mr Patel had reflected on his misconduct and had taken time out for a period of self-reflection between March and July 2020. He referred to the course certificates provided by Mr Patel. He referred to the examples of circling of dose and strength information on prescriptions and the label on the medication pack as a practical precautionary measure Mr Patel had implemented. He referred to a schedule of locum engagements as demonstrating that the hours worked by Mr Patel were no longer excessive and that Mr Patel now preferred to work for larger pharmacy chains including Boots and Lloyds, in which there were better arrangements to cover staffing, including contingency plans.

40. Mr Lister referred to testimonials which confirmed that Mr Patel had been working safely as a pharmacist since the events of 2019.

41. Mr Lister submitted that there was a low likelihood of repetition of the misconduct.

42. *5 (2) (b)*. Mr Lister submitted that, having regard to the nature of this case, involving a series of errors, the public would understand that, despite the grave consequences of those errors, the misconduct in question would not necessarily bring the reputation of the profession into disrepute.

43. *5 (2) (c)*. Mr Lister conceded that, having breached Standards, Mr Patel had breached "one of the fundamental principles of the profession".

**Determination on misconduct and Impairment**

44. We accepted legal advice and took account the guidance given to the meaning of 'fitness to practise' in the guidance. 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."*

45. We took into account the submissions made by Ms Tompkinson and Mr Lister. We had regard to all of the documentary evidence before us.

**Decision on misconduct**

46. We find that Mr Patel made an error in his professional judgement in agreeing to work to help out in a staffing crisis at Crompton pharmacy and compounded that error by going on to dispense a controlled drug without a second checker. He made an initial error on 11 November in preparing a label for a strength of medication in excess of the prescribed strength and ordering stock on this basis. He then missed the opportunity to check the prescription against the label on the pack, when Witness 1 raised a concern the next day. His communication was lacking as he narrowly interpreted her concern about the dose as referring only to frequency rather than strength.

47. We considered whether Mr Patel had breached any of the Standards. We find that Mr Patel breached the following:

    a. Standard 1 - Pharmacy professionals must provide person centred care

       He failed to listen to Witness 1 and to respond to her concerns by checking the prescription.

    b. Standard 3 - Pharmacy professionals must communicate effectively.

       There was a failure to listen actively which had catastrophic consequences. Witness 1 may have been using the language of "dose" rather than "strength" but her concern should have been a red flag and alerted Mr Patel to the need to check the prescription.

    c. Standard 5 - Pharmacy professionals must use their professional judgement.

       Mr Patel made a number of serious errors of professional judgement in working excess hours, in practising in an environment where there was insufficient staffing support, in continuing to supply a controlled drug without the support of a second checker and in working when he was stressed and overtired.

48. We bore in mind that a breach of the Standards does not automatically result in a finding of misconduct, referencing Rule 24(11).

49. We consider that, in this case and despite the unusually pressured circumstances following a bereavement, the illness of a locum and general understaffing of the

Crompton pharmacy, Mr Patel's actions and his breach of the Standards is serious enough to amount to misconduct.

**Decision on Impairment**

50. Having found that the particulars of the proven allegation amounted to misconduct, we went on to consider whether Mr Patel's fitness to practise is currently impaired. In doing so we considered whether the particulars found proved show that his actions/ omissions:

- *present an actual or potential risk to patients or to the public [Rule 5(2)(a)]*
- *has brought, or might bring, the profession of pharmacy into disrepute [Rule 5(2)(b)]*
- *has breached one of the fundamental principles of the profession of pharmacy [Rule 5(2)(c)]*
- *we note the integrity of the registrant is not at issue in this case*

51. We first considered whether Mr Patel presents an actual or potential risk to patients or the public.

52. We took into account that Mr Patel, who registered as a pharmacist in 1995, has no previous concerns, nor has there been any concern since the events of November 2019. It is of significance that he has not been under any interim restriction and has been practising unrestricted and with no further concerns, for nearly four years.

53. We have before us two professional testimonials. Witness 5 and Witness 6, in a signed statement dated 31 August 2023, state that they have seen the allegations. They manage a community pharmacy and Mr Patel worked as a locum pharmacist between January and August 2021. They describe him as being "process driven and his expertise gave him good judgement". He gave a lot of time to explain issues or questions to staff and patients. Witness 7, Pharmacy Manager at Boots Greenbridge Swindon, provided a testimonial signed and dated 31 August 2023. He confirms having seen the allegations. He states that Mr Patel has been employed as a locum pharmacist over the last 12 months and that "the level of care he gives our customers

[is] exemplary". He commends Mr Patel for adopting the specific detailed procedures for all pharmacy processes at Boots.

54. We find that Mr Patel has reflected deeply on his misconduct. In his witness statement signed and dated 1 September 2023, he accepts that, having heard Witness 1's concerns, he "should have gone and checked the prescription something that haunts me to this day and something that I will never be able to forget."

55. Mr Patel says that he now understands that patients do not view prescriptions in the way that he would, as pharmacist. He says, "I have come to realise that when a lay person is talking about dose and strength, the meaning for them is the same so I will always be mindful of this in future." He says that "going forward I now always double check if I am asked anything related to a prescription." As regards working with only the support of a trainee dispenser, he says: "I know now that if I find myself in this type of situation again, I need to raise it immediately as I can only be effective in my role with a sufficient team around me."

56. We accept that Mr Patel did not know until 12 November 2019 that the trainee dispenser was not allowed to check any CD prescriptions. We have no evidential basis sufficient to draw any contrary inference and we do not enter into speculation regarding the possibility of prior awareness of this issue.

57. We considered the quality of Mr Patel's insight. He accepted his mistake at a very early stage, as evidenced in the witness statement of Witness 4. He made no attempt to conceal his error and was open about this at the Coroner's inquest. His concession as to the facts alleged, misconduct and impairment, all demonstrate that he has developed a high level of insight, not only into his negligent actions, but also the level of seriousness, including an admission of a breach of the Standards.

58. The evidence indicates that there were staffing and procedural issues at the Crompton pharmacy which Witness 4 had subsequently rectified in the light of the events of November 2019. We do not consider that, in drawing attention to these factual circumstances, Mr Patel has sought to shift blame. He explicitly states: "I do not want to remove myself from my responsibility nor minimise my actions in any way, shape or form…" We accept that this was explanation as to the circumstances.

59. Ms Tompkinson submitted that Mr Patel had failed to show insight into deep-seated attitudinal issues, including underlying reasons why he had made his errors. We consider that Mr Patel has reflected deeply and has shown insight both into the specific errors and the background circumstances, including excess working hours and being willing to work without proper staffing support, in which these errors occurred.

60. Mr Patel has shown genuine remorse and we are particularly impressed by the evidence that he apologised direct to Witness 1 in public at the Coroner's inquest.

61. Mr Patel has undertaken a number of courses relevant to remediation of his errors and to reduce the risk of making other types of errors. These include courses on risk management, "look alike sound alike" errors, consultation skills, a person-centred approach, remote consultation skills, basic observations, safeguarding and antimicrobial stewardship. Some of these courses appear to us to be highly relevant to the quality of communication and listening to patients or their representatives. Mr Patel has adopted practical measures to reduce the risk of misreading prescriptions (circling the dose and strength on the face of the prescription and the label on the medication pack). He has reduced his working hours, closed his online pharmacy business and prefers now to work for larger pharmacy chains in which there are procedures in place to deal with understaffing, including contingency plans. He has thereby put in place measures to avoid finding himself again in the same circumstances in which his catastrophic errors occurred in November 2019.

62. For all of the above reasons, we find that Mr Patel does not present an actual or potential risk to patient or the public. His fitness to practise is therefore not impaired on grounds of public protection.

63. Mr Patel committed a series of avoidable errors which had catastrophic consequences. It was found at a Coroner's inquest that Patient A died as an accidental overdose of oxycodone which "was the result of a dispensing error of her prescribed medication". Because of the seriousness of the errors, amounting to misconduct and in breach of the Standards and mindful of the resultant death of Patient A, we find that Mr Patel has brought the profession into disrepute. We do not consider that, looking to the future, he "might bring" the profession into disrepute. Our finding relates only to his past misconduct.

64. The fundamental principles of the pharmacy profession may be found by reference to the Standards. We have found, under the heading of misconduct, that Mr Patel has breached Standards 1, 3 and 5. As such, he has failed to provide "safe and effective care". We find that he has breached fundamental principles of the profession.

65. We therefore find Mr Patel's current fitness to practise to be impaired on public interest grounds and accordingly must continue the hearing to consider submissions and any evidence on the issue of sanction.

**Decision on sanction**

66. Having found impairment, we went 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 least restrictive, take no action, to most restrictive, removal from the register, in order to identify the appropriate and proportionate sanction that meets the circumstances of the 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 professional standards. The Committee is therefore entitled to give greater weight to the public interest over the Registrant's interests.

68. We accepted legal advice and had regard to the guidance. The legal advice, in addition to commending the guidance, referred to a number of aspects which arose in submissions. We should base our decision on our existing findings. We should not speculate on matters on which we had not received evidence.

69. At the outset of this stage of the case, we heard an oral statement, provided also in writing, from Mr Patel. Mr Patel said:

" I accept that the mistakes I made were grave mistakes for which I apologise unreservedly to Witness 1's and family concerned. I can not even put into words how they must feel. I feel completely devastated for my part in these terrible mistakes. I can recall the day when I made a face to face public apology at the inquest to Witness 1 and family and found to be a particularly harrowing experience. No pharmacist can possibly conceive having to do this because their primary focus is to help the sick and

help to make them better. That day's memory serves as a constant reminder to me to strive to do better.

" I had hoped to end my career with my head held high and a record that was unblemished. I still want to continue with my career and I am prepared to follow whatever guidance or conditions the GPHC deem necessary to satisfy the public's faith in me as a pharmacist and to maintain the integrity of this wonderful profession. I apologize for bringing it into disrepute."

70. The committee took into account the submissions made by Ms Tompkinson and Mr Lister.

71. We were addressed by the representatives on a variety of matters and, in relation to matters which are not before us in evidence, we do not enter into speculation. We base our decision on sanction on our existing findings as regards the facts, the agreed background facts, misconduct and impairment. Ms Tompkinson invited us to find that there was a lack of insight in one sentence of Mr Patel's statement made at the outset of this stage. We do not find anything in his statement to undermine our earlier findings as to insight, upon which we rely. Ms Tompkinson invited us to consider that there had been inconsistency and delay in Mr Patel making admissions in relation to facts, misconduct and impairment. We have no evidence to suggest that Mr Patel ever varied from his very early admission of the underlying facts of his errors. We cannot treat actions by Mr Patel at the investigation stage of these procedures (on which we do not have evidence) or decisions on his conduct at this hearing (such as his reliance on submissions and a written statement of evidence) as aggravating factors. Nor can we speculate about the potential impact on a witness (on which we have no evidence) of any delay on the part of Mr Patel in clarifying his position ahead of this hearing.

72. We considered any aggravating and mitigating factors in this case.

73. We identified the following aggravating factors:

    a. This is a case in which, as conceded by Mr Lister, there was harm to a patient, as Patient A died as a result of Mr Patel's errors.

b. The errors arose against a background of Mr Patel making errors of professional judgement by working excessive hours, including when he was stressed and overtired.

c. Mr Patel made an error of professional judgement in agreeing to work in a situation where there was insufficient staffing and to supply a controlled drug without a second checker.

74. We identified the following mitigating factors:

a. The misconduct in this case occurred by a series of avoidable errors over a two day period on 11 and 12 November 2019. There have been no other concerns in the prior 24 years of Mr Patel's registration, nor since.

b. Mr Patel has shown remorse from an early stage, including by giving a public apology direct to Witness 1 at the Coroner's inquest. He has repeated his apology and expression of remorse by his oral statement at this hearing.

c. Mr Patel has, as recorded in our detailed findings at para 62 above, comprehensively remediated his errors. He does not currently pose a risk to patient safety.

d. As confirmed by professional testimonials, Mr Patel has been working for nearly four years since the incident without restriction and without concerns. The testimonial from a current locum employer describes the level of care which he provides as exemplary, commends his adoption of specific detailed procedures and his help for new members of the team (in a Boots community pharmacy).

75. We went on to consider the available sanctions in ascending order.

76. This is a case in which it is necessary to declare and uphold the Standards and to maintain public confidence in the reputation of the profession. It is clearly not appropriate to take no action.

77. We gave careful consideration as to whether a warning or a more severe sanction would be appropriate in all the circumstances of this case. We considered that a case in which the misconduct has been remediated to the extent that there is not a risk to patients or the public, is not suitable for conditions. So that the next available

sanction, in this case, would be suspension (a point conceded by Mr Lister). Mr Lister proposed that a warning would suffice. Ms Tompkinson submitted that Mr Patel should be suspended for a period of no less than 3 months, with a review.

78. We considered that both a warning or a suspension would serve to declare and uphold the Standards. Both would be in the public domain. A warning would be recorded on the Council's register for a period of one year, a suspension for two years. The question in our minds was therefore whether the seriousness of this case demanded the level of public demonstration of the significance of Mr Patel's breach of the Standards which would be achieved by a suspension.

79. We weighed in the balance that a suspension would prevent Mr Patel from working for the period of the suspension. Of greater concern for us was that, as Mr Patel has been working unrestricted for nearly four years and is currently serving the public as a locum pharmacist, a suspension would deprive the public of his evidently competent and caring services, for the period of the suspension. We concluded that, despite the catastrophic results of Mr Patel's errors, well-informed members of the public would not expect to lose the services of a pharmacist for even a short period, if it were possible to declare Standards and uphold the reputation of the profession by a less severe sanction.

80. For all of these reasons, we concluded that a warning, which will be on the Council's register for a period of one year, will suffice to declare and uphold the Standards and maintain public confidence in the profession.

81. Accordingly, we warn Mr Patel in the following terms:

- *The Standards for pharmacy professionals (May 2017) ("the Standards") are intended to ensure that pharmacists provide safe and effective care to patients.*
- *As a result of your errors in the dispensing and supply of a controlled drug to a patient in November 2019, that patient suffered an overdose which contributed to her death. You have been found to have breached the Standards and to have brought the profession into disrepute by your misconduct.*
- *Since the time of the incident, you have remediated your pharmacy practice and have been practising without restriction or any concerns. It is not considered that you pose a risk to patients or the public. The purpose of this warning is to remind*

*pharmacy professionals and the public of the Standards which pharmacists are expected to meet at all times.*

- *This warning will be published on the Council's Register and will be available for 12 months.*

82. We therefore direct that the Registrar convey the above warning to Mr Patel and that it be recorded on the Council's register.

83. This concludes the determination.