On **15 January 2024** the General Pharmaceutical Council's Investigating Committee considered an allegation in relation to **Mr Daniel Mark Lee, registration number: 2039891** and determined to issue the registrant concerned with a warning in relation to the conduct alleged.

The Committee concluded that the appropriate outcome in this case is a warning with the wording of:

Mr Daniel Mark Lee is the Superintendent Pharmacist (SI), Responsible Pharmacist (RP), and Director of Cloud Rx in Leeds.

- CloudRx, at the relevant time, operated an online prescribing platform. It provided a web-based service whereby prescribers could electronically prescribe in compliance with electronic prescribing service guidance. It was a service primarily targeted at clinics and prescribers working within such settings and who were prescribing after direct patient facing consultations. Prescriptions would then be dispensed by CloudRx.

- However, as became apparent from the incident reported to the GPhC, there were systemic weakness and other prescribers (both non-UK, but also those prescribing using questionnaire based models with little or no patient contact), were using the CloudRx prescribing platform.

- Patient A was a particularly vulnerable patient who was on a daily prescription and daily dispensing regime due to the real risk of overdosing and self-harm.

- Notwithstanding the real risk, Patient A was able to secure three supplies of Amitriptyline, none of which were clinically appropriate or safe, through CloudRx. The prescriptions were issued by a non-UK registered/regulated doctor on the basis of an online, questionnaire-based consultation. Mr Lee was Responsible Pharmacist on one of the three occasions when supply was made to Patient A.

The supply to Patient A was dangerous, in that repeat supplies were being authorised by prescribers using the CloudRx portal of a high-risk medicine before a previous supply could have been exhausted or any monitoring being undertaken. Fortunately, a social worker was able to intervene before Patient A was able to attempt any overdose or self-harm.

Mr Lee had, as Superintendent Pharmacist, overall responsibility for the systems used in the pharmacy.

After the report of these events, the pharmacy was inspected; the standards were not all met and key failures were identified including the adequacy of risk assessments, audits and properly managing the risks associated with questionnaire based prescribing services and prescribers and prescribing services not regulated in the UK and therefore not obliged to follow UK prescribing frameworks. These were failures which had the potential to lead to unsafe prescribing and inappropriate supplies as came to pass with Patient A.

An improvement action plan was implemented, and the pharmacy was again inspected, 11 months later, when it met the standards.

Mr Lee was the RP on 14 June 2021. He was also the SI. Mr Lee's conduct has breached the following GPhC standards for pharmacy professionals.

Standard 2: Pharmacy professionals must work in partnership with others.
Standard 3: Pharmacy professionals must communicate effectively.
Standard 4: Pharmacy professionals must maintain, develop and use their professional knowledge and skills.
Standard 5: Pharmacy professionals must use their professional judgement.

Acknowledging the mitigation, insight, remorse and explanation Mr Lee has provided, as well as the changes in processes that have been made, he is reminded of his statutory responsibilities in the operation of the pharmacy, in that 'the retail

pharmacy business, so far as concerns the keeping, preparing and dispensing of medicinal products other than medicinal products on a general sale list, is under the management of a superintendent'. Although the obligation for meeting the pharmacy standards falls on the owner, the SI can be held to account for failings in the management of any of the pharmacy services – including any system, processes and policies covering these activities.

In respect of the pharmacy professional acting as the RP he would also have had a statutory, role in the operation of the pharmacy, including the obligation to 'establish (if they are not already established), maintain and keep under review procedures designed to secure the safe effective running of the business'.

To mark the seriousness of the issue, Mr Lee is warned that such conduct must not be repeated and that he must, at all times, adhere to the Standards for Pharmacy Professionals and to meet the statutory obligations of an RP or SI.

Any repetition of this or similar conduct is likely to result in further regulatory intervention.

This warning will be published on the register and will be available for 12-months.