General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote videolink hearing

Monday 29- Wednesday 31 January 2024

Registrant name:	Sarah-Jane Forrest
Registration number:	5001693
Part of the register:	Pharmacy Technician
Type of Case:	Misconduct
Committee Members:	Lubna Shuja (Chair) Surinder Bassan (Registrant member) Wendy Golding (Lay member)
Committee Secretary:	Adam Hern
Registrant:	Not Present and not represented
General Pharmaceutical Council:	Represented by Priya Khanna, Case Presenter
Facts proved:	1, 2, 3, 4, 5.2, 6 and 7
Facts proved by admission:	None.
Facts not proved:	5.1
Fitness to practise:	Impaired
Outcome:	Removal
Interim measures:	Interim suspension

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 29 February 2024 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 pharmacy technician, whilst you were working at Omnicare Pharmacy, 2 Home Street, Edinburgh, EH3 9LY ('the Pharmacy') operating from the Queensferry Road Branch and the Tollcross Branch:

1. On or around the following dates you removed 56 x tablets of Oxycodone 20mg MR from the Queensferry Road Branch:

    1.1. 22nd December 2020
    1.2. 2nd February 2021
    1.3. 18th February 2021
    PROVED.

2. On 11th March 2021, you removed from the Tollcross Branch 56 x tablets of Oxycodone 30mg MR. **PROVED.**

3. Your actions in relation to allegations 1 and 2 above were dishonest in that:

    3.1. You did not have permission and/or authority to remove the medicines from the pharmacy.
    3.2. You knew you did not have permission and/ or authority to remove items from the pharmacy.
    3.3. You removed the medicines for your own use/ benefit.
    PROVED.

4. On or around the following dates you falsified the controlled drug register at the Queensferry Road Branch by entering incorrect details that Patient C had been dispensed 56 x tablets of Oxycodone 20mg MR:

    4.1. 22nd December 2020
    4.2. 2nd February 2021
    4.3. 18th February 2021.

    PROVED.

5. On or around the following dates you falsified Patient C's Patient Medical Record by making an entry for 56 x tablets of Oxycodone 20mg MR:

    5.1. 3rd December 2020 **NOT PROVED.**
    5.2. 22nd December 2020 **PROVED.**

6. On 11th March 2021, you falsified the Controlled Drug Registers at the Tollcross Branch by entering incorrect details that Patient X had been dispensed 56 x tablets of Oxycodone 30mg MR.

7. Your actions in relation to allegation 4 and 5 and 6 above were dishonest in that you knew that the entries were false and/or incorrect. **PROVED.**

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

Documentation

- The Council's hearing bundle (71 pages)
- The Council's Service Bundle (9 pages)
- The Council's Proceeding in Absence Bundle (85 pages)
- Correspondence between the Registrant and the Council from 1 August 2023 to 3 September 2023 (4 pages)
- Email dated 4 September 2023 from the Council's Case Officer to the Registrant
- The Council's Skeleton Argument dated 18 January 2024
- Email dated 28 January 2024 from the Registrant to the Council

Witnesses

Mr 1, Superintendent Pharmacist - gave evidence at facts stage

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 had seen a letter dated 5 December 2023 from the Council headed 'Notice of Hearing' addressed to Ms Sarah-Jane Forrest ("the Registrant"). It was sent to the Registrant's registered postal address and to her registered email address.

7. There had been some correspondence between the Registrant and the Council about her email address. On 19 August 2023 the Registrant had informed the Council, using her registered 'hotmail' email address that that email was not her primary email. She did not provide an alternative email until 3 September 2023 when she advised the Council of her current 'gmail' email address. However, she did not update her

Council records so her registered email remained as the 'hotmail' address. Her registered postal address did not change.

8. The Committee noted the Notice of Hearing had been sent by post and by email. Although it was sent by email to an address the Registrant said was not her primary email, it was her registered email and she had corresponded with the Council using it as recently as 28 January 2024. The Committee was satisfied that there had been good service of the Notice in accordance with Rules 3 and 16 of the Rules.

Application to proceed in the absence of the Registrant

9. The Registrant was not in attendance at this hearing and was not represented. The Committee heard submissions from Ms Khanna under Rule 25 of the Rules to proceed in the absence of the Registrant.

10. The Committee noted that in addition to the Notice of Hearing which had been sent to the Registrant on 5 December 2023, other letters had been sent to her by post and by email on 18 September 2023, 10 January 2024 and 19 January 2024. The letter of 18 September 2023 had been sent by Recorded Delivery and had been confirmed as delivered on 23 September 2023. An email had also been sent by the Council to her registered 'hotmail' address on 25 January 2024 reminding her of the hearing date and containing a link to join the remote hearing.

11. In response to that email, the Registrant had sent an email to the Council dated 28 January 2024 in which she stated:

> *"Unfortunately I'm unable attend as I'm working and it's an extremely important week this week so can't get time off. I will await to hear the outcome.*
>
> *I have missed a couple of recorded delivery letters and I'm not sure if they are from you. I'm in the office all week so I can't reschedule delivery until the following week."*

12. The Committee was satisfied that the Registrant was aware that today's hearing was taking place. She was also clearly aware of the nature of these proceedings as the Council's letter dated 18 September 2023 had been delivered to her. It had attached details of the allegations, the Council's bundle and details of witnesses the Council intended to rely upon as well as other relevant information.

13. The Committee concluded the Registrant had voluntarily absented herself from the hearing. She had not requested an adjournment and had said she would wait to hear "the outcome". This implied she did not intend to engage with the proceedings and wished the hearing to continue without her. She was unlikely to engage in a future hearing even if the today's hearing were to be adjourned.

14. The Committee took into account the Registrant had engaged with her employer's investigation. She had attended a meeting with her employers and her replies to their enquiries were before the Committee. There were also a number of emails from her to both her employers and the Council which the Committee could take into account.

15. The Committee noted the allegations were serious and included dishonesty. A witness was in attendance to give evidence. Further delay would inconvenience that witness and could impact on his recollection of events. The Committee concluded it was in the public interest, as well as in the Registrant's interests, for the case to be concluded expeditiously. Accordingly, the Committee decided to proceed in the Registrant's absence.

Application to amend the Allegation

16. The Committee heard an application from Ms Khanna under Rule 41 to amend Allegation 7 as follows (proposing the addition of the underlined words):

> "*7. Your actions in relation to allegation 4 and 5 <u>and 6</u> above were dishonest in that you knew that the entries were false and/or incorrect.*"

17. The Registrant had been informed of the proposed amendment in a letter from the Council sent to her registered postal address and her email on 10 January 2024. She had also been sent the Council's Skeleton Argument and Final Hearing Bundle on 19 January 2024. The Skeleton Argument confirmed an application to amend Allegation 7 was to be made. The Committee was satisfied the Registrant had had sufficient notice of the proposed amendment and had not made any representations about the application.

18. The Committee took into account that the proposed amendment was an additional allegation of dishonesty which was a serious allegation. However, Allegation 6 already alleged the Registrant had "falsified" the Controlled Drug Registers, which in itself was a dishonest act. The Committee was satisfied that the proposed amendment did not add anything new to the case and the nature of the amendment reflected the evidence already relied upon. The Committee concluded it was in the public interest to allow the amendment and therefore granted the application.

Application for the hearing to be held in Private

19. It was apparent from the documents produced that there may be reference to the Registrant's health and her private life during the hearing. In light of this, the Committee took the view that it may be appropriate to hold those parts of the hearing in private under Rule 39(3) of the Rules in order to protect the Registrant's right to privacy. Ms Khanna, on behalf of the Council, was invited to make submissions in relation to this. She did not oppose.

20. Accordingly, the Committee decided to hold certain parts of the hearing in private to allow the Council and any witnesses to refer to the Registrant's health and her personal circumstances. This would maintain the Registrant's right to privacy whilst ensuring the Committee was provided with all relevant information.

Background

21. Ms Sarah-Jane Forrest ("the Registrant") is a Pharmacy Technician, who first registered with the Royal Pharmaceutical Society of Great Britain on 16 August 2005 and is now registered with the Council under registration number 5001693.

22. The Registrant was employed by Omnicare Pharmacy, 2 Home Street, Edinburgh, EH3 9LY ("the Pharmacy"). She had worked for the Pharmacy for about 10 years and had been the Area Co-Ordinator for approximately three years. She had worked at both the Queensferry Road Branch and the Tollcross Branch of the Pharmacy. She was a full-time employee with responsibilities for recruitment, training, supporting branch managers and rotas.

23. On 15 March 2021, Colleague A, a branch manager at the Pharmacy's Tollcross Branch, informed Mr 1, the Pharmacy's Superintendent Pharmacist, that there were some *"controlled drug discrepancies"* at that Branch. The Controlled Drug in question was Longtec (a brand name for Oxycodone), 30mg MR (56). An entry had been made on Patient X's Patient's Medical Record ("PMR") on 11 March 2021, without a prescription being issued by the GP. Patient X had visited the Tollcross Branch concerning other medication when the manual entry on the patient's PMR was noted. On this occasion, there was a manual entry on the PMR with no corresponding barcode which was unusual as normally the bar code from the prescription would be entered.

24. Patient X had previously been prescribed Oxycodone, in June 2020. However, no prescription for this drug had been issued to Patient X since June 2020. Patient X's GP practice also confirmed there was no prescription in place for Patient X for Oxycodone around 11 March 2021.

25. On 16 March 2021, Mr 1 attended the Tollcross Branch of the Pharmacy to commence his investigation. Having made enquires with Patient X's GP practice, Mr 1 examined two Controlled Drug Registers ("CD Register") one for Oxycontin (a brand name for Oxycodone) and the other for Oxycodone. Each CD Register had an entry, dated 11 March 2021 for 28 tablets and recorded the patient had collected 56 tablets in total.

26. Mr 1 also viewed the Pharmacy's CCTV footage from 11 March 2021. He made the following observations from the footage:

> "*The Registrant can be seen picking up the controlled drug ("CD") cabinet keys at 14.12 and then going into a room with a basket and comes back still with a*

basket, she then goes back to the bench and bags up the boxes from the basket and leaves the bag on the bench. It is not clear if it was the Oxycodone box, but it appeared to look like a box of Oxycodone. I believe the Registrant then goes to the PMR and CD record on the computer and makes an entry. You cannot see exactly what she is entering on the computer but she is in that area towards the bottom right of the screen at 14.17 and the PMR record for Patient X marks the entry around 14.15 – I believe the clocks are slightly out of sync as this coincides with the CCTV footage showing the Registrant at the computer. There is nobody else at the computer around this time".

27. Mr 1 observed the Registrant on the CCTV footage return to the bench, pick up the bag and head to the staff room, where she appeared to place the bag inside her own handbag. The Registrant returned from the staff room to resume work at the bench, without the bag, but with a mobile phone and a purse.

28. On 17 March 2017, Mr 1 contacted the Registrant to ask her to attend a meeting to discuss his findings. The Registrant did not come in but instead sent an email stating:

> "*I don't want this going any further with you interviewing staff and getting them into trouble. It was me that did it and I am so ashamed that I can't come in.* [PRIVATE] *I put the money the drugs cost in the till and still can't believe I would do that and you will never know how sorry I am*. [PRIVATE] *I love working for you both and always felt like we were like a wee family and I am disgusted with myself. I know now by doing it I have now lost absolutely everything. If my years of dedication means anything at all could you please please not call the police* [PRIVATE]*. If you have to then please could you wait until tomorrow* [PRIVATE] *and if possible let me know so I can prepare myself. Please say a massive sorry to [Colleague A] as well for putting him under the stress. I thought it wouldn't really do any harm but it was obviously the worst call ever* [PRIVATE]. *I hope there is a way you can forgive me in the future because I really didn't mean any harm to you both and your business. Omnicare has been my life for 10 years and I am so so sorry and wish nothing more than to turn back the clock and never make such a stupid mistake."*

29. On receiving the Registrant's email of 17 March 2021, Mr 1 [PRIVATE] visited her at home with a colleague. The Registrant admitted to Mr 1 that she had also taken drugs from the Queensferry Road Branch of the Pharmacy.

30. Mr 1 then conducted a "full audit" of the controlled drugs held at the Queensferry Road branch and identified discrepancies between Patient C's CD Register, Patient C's PMRs and what Patient C had been prescribed by their GP.

31. Colleagues B and G held a disciplinary meeting on 1 April 2021 which the Registrant attended. During that meeting the Registrant made a number of admissions. She was unable to remember patient names. At the meeting, the Registrant read out a statement from her phone.

32. In an email dated 2 April 2021 from the Registrant to Colleague B and Mr 1, the Registrant submitted her resignation.

33. An expert report dated 18 October 2021 had been provided by a Senior Scientist from Cansford Laboratories.

Decision on Facts

34. In reaching its decisions on facts, the Committee considered all the documentation listed at the start of this determination, the oral evidence and the submissions made by the Council. It took into account all the material available to it from the Registrant.

35. When considering each of the Allegations, the Committee bore in mind that the burden of proof rests on the Council and that Allegations are found proved based on the balance of probabilities. This means that Allegations will be proved if the Committee is satisfied that what is alleged is more likely than not to have happened.

36. The Committee viewed the CCTV footage from the Pharmacy for 11 March 2021 and heard evidence from Mr 1. He had also been able to identify the discrepancies at the Queensferry Road Branch by considering the electronic documents he had access to. The quantity of tablets supplied without a prescription were, on each occasion, 56 in number. This was the same quantity taken at the Tollcross Branch in March 2021.

37. The Committee found Mr 1 to be a credible and straight forward witness. He gave his evidence in a clear and concise manner and the Committee believed what he said. He also took the Committee to contemporaneous records that he had printed from the various computer systems at both the Queensferry Road and the Tollcross Road branches of the Pharmacy and explained their content in detail. He gave evidence about the processes and procedures used at the Pharmacy when recording Controlled Drugs and explained that all prescriptions for Controlled Drugs contained a bar code which would be entered on the relevant patient's PMR as the prescription was being processed. If a bar code was not recorded (which was unusual), this would indicate a manual entry had been made.

38. Mr 1 confirmed the Registrant had worked at the Pharmacy for some 10 years and there had never previously been any issues with her work or conduct. He confirmed that the Registrant had been invited to view the CCTV footage and although she did not do so, she was aware it existed and had been provided with a summary of what it showed. Mr 1 confirmed the matter had also been reported to the police. He stated that he had spoken to other staff at the Pharmacy and they did not recall receiving any money from the Registrant for any Controlled Drugs.

39. The Committee took into account the various emails that the Registrant had sent to the Council and also to her employers. She had made reference to personal difficulties in some of these. It also took into account what she had said during the disciplinary meeting on 1 April 2021.

40. The Committee considered the expert report dated 18 October 2021 from the Senior Scientist. She had analysed samples of the Registrant's hair covering the period 28 September 2020 to 23 September 2021. She concluded:

> "The findings *support the use of Oxycodone within or prior to the investigated time period covered by the earliest hair section tested. For information, the level of Oxycodone detected is in the low range when compared to other positive samples we have tested. The earliest section tested represents the approximate time period from 28 September 2020 to 27 December 2020. Oxycodone was not detected in the three most recent sections tested, indicating that the Oxycodone use by Sarah-Jane Forrest had ceased*.
>
> *It was declared that hair dye and bleach had been used on approximately 15 August 2021. The level of drugs and drug metabolites present in hair can be reduced by the use of chemical treatments that damage the hair, for example hair dye/chemical lightening. It is therefore possible that concentrations of drugs and drug metabolites in any treated hair have been reduced*."

Allegation 1: On or around the following dates you removed 56 x tablets of Oxycodone 20mg MR from the Queensferry Road Branch:

1.1 22nd December 2020
1.2 2nd February 2021
1.3 18th February 2021

41. The Committee considered carefully all the contemporaneous records it had been referred to together with the explanations of these provided by Mr 1. Allegation 1 concerned Patient C at the Queensferry Road Branch of the Pharmacy.

42. Mr 1's attention had been drawn to investigating the Queensferry Road Branch as a result of the Registrant informing him in person on or around 17 March 2021 that she had taken "more" from that branch. She could not be specific about when or which medication she had taken so Mr 1 had been prompted to carry out a full audit of the records at that branch.

43. Mr 1 noted that Patient C received a weekly supply of 14 Oxycodone 20mg tablets. These were logged in the CD Register on 10 December 2020, 17 December 2020 and 23 December 2020. A further supply was entered on 22 December 2020 for 56 Oxycodone 20mg tablets notwithstanding Patient C had received weekly supplies on the other recent dates. This entry contained the Registrant's initials. Mr 1 contacted Patient C's GP surgery who confirmed no additional prescriptions had been given.

44. Another entry had been made in CD Register on 2 February 2021 for 56 Oxycodone 20 mg tablets for Patient C which contained the Registrant's initials. A further entry had been made in the CD Register on 18 February 2021 for 56 Oxycodone 20mg

tablets for Patient C. This entry did not contain the Registrant's initials but had initials of other staff members. However, by this time Patient C's prescribed dose had increased to 40mg.

45. The Committee's attention was drawn to a screenshot of Patient C's prescription entry and dispensing. It showed that the entry on the CD Register of 22 December 2020 had no bar code so was entered manually by the Registrant.

46. During the investigation meeting on 1 April 2021, the Registrant accepted she had falsified these Controlled Drug and patient records. She stated:

> "*Even the ones that are detailed are probably right but the whole thing is a blur. I take full responsibility, but I couldn't remember patient names or anything like that.*"

47. The Registrant then read out a statement from her phone referring to her personal issue and apologising for "*any hurt caused*". She was asked why she had done this multiple times to which she replied:

> "*I did it the first time, panicked [PRIVATE] In a way I think I wanted to get caught. My head has been mince for the last six months, I don't remember the last six months.*"

48. The Committee concluded that the contemporaneous records showed the Registrant had made the false entries on 22 December 2020 and on 2 February 2021 as they both contained her initials. She had admitted doing so. It could be inferred that she had also made the entry on 18 February 2021 as the strength of Patient C's medication had changed by this point. The Registrant also admitted making these entries and removing the medication during her disciplinary meeting on 1 April 2021. There could be no reason for her to have made those entries other than that she had removed the drugs. It was also pertinent that Patient C was only prescribed quantities of 14 tablets on each supply, whereas the entries on 22 December 2020, 2 February 2021 and 18 February 2021 were all for 56 tablets.

49. The Committee was satisfied that it was more likely than not that the Registrant had removed 56 Oxycodone 20mg tablets from the Queensferry Road Branch of the Pharmacy on the dates alleged due to the false entries that had been made.

50. Allegation 1 is found proved.

Allegation 2: On 11th March 2021, you removed from the Tollcross Branch 56 x tablets of Oxycodone 30mg MR.

51. This Allegation related to Patient X's records. The Committee had carefully considered the CCTV footage from 11 March 2021 of the Tollcross Branch of the Pharmacy. For the Committee's benefit, Mr 1 had identified the Registrant in the CCTV footage and the Committee observed her conduct from 14:10 to approximately 14:39 when the alleged incident happened. Mr 1 confirmed that the Controlled Drug

("CD") cabinet was located in the staff room where staff kept their personal belongings. That room did not have CCTV.

52. The footage showed the Registrant picked up the Controlled Drug ("CD") cabinet keys at 14:12 and proceeding, with a basket that appeared to have a prescription in it, to the room where the CD Cabinet was located. She emerged from that room with at least one medication box in the basket. She placed the basket on her work bench. She then proceeded to put 2 medication boxes into a bag, put a label on the bag and placed the bag on the shelf for patient collection. She went back to her work bench, removed a box from the basket she had brought out of the CD room and placed it in a bag which she folded over with no label ("the unlabelled bag"). That bag remained in the same position on the Registrant's work bench for approximately 25 or so minutes. At 14:17, the Registrant went to the computer where she appeared to be working. Mr 1's evidence was that the records showed she was entering information on Patient X's records and on the CD register at that exact same time. The Registrant then returned to her work bench and continued working, with the unlabelled bag remaining unmoved in the same position.

53. At 14:37, the Registrant picked up the unlabelled bag and walked towards the CD cabinet room, where her bag was stored. As she approached the room, she appeared to see the Pharmacy Manager in the room and she immediately turned around and went back to her work bench with the unlabelled bag which she placed back on her work bench. The Pharmacy Manager went from the CD cabinet room into the adjoining store room. When he had come out of the store room and moved away from the area, the footage showed the Registrant take the unlabelled bag, go back into the CD cabinet room where her bag was stored and she could be seen bending down over bags close to the doorway. When the Registrant emerged from the CD cabinet room, she had her mobile phone in her hand and her purse under her arm. There was no sign of the unlabelled bag.

54. When asked about the missing medication, the Registrant in her email of 17 March 2021 to Mr 1 stated:

> "It was me that did it…… I put the money the drugs cost in the till…. I thought it wouldn't really do any harm…. I am so so sorry and wish nothing more than to turn the clock back and never make such a stupid mistake."

55. Although the CCTV footage did not clearly show the medication that was in the basket which the Registrant had taken from the CD Cabinet, a colleague at that branch had reported there was an entry of 56 Oxycodone 30mg tablets in the CD Register on 11 March 2021 without a prescription being issued by the GP. Mr 1 had examined Patient X's records and spoken to Patient X's GP surgery who confirmed he had not been issued with a prescription for that medication on that date. Mr 1 also identified entries had been made in the CD Register by the Registrant for Patient X on the same day at around 14:14 to 14:15 which coincided with the CCTV footage showing the Registrant at the computer at this time.

56. The Committee took into account the Registrant's admissions in her email of 17 March 2021. She had also made admissions of falsifying patient records during the investigation meeting on 1 April 2021. It was clear from the CCTV footage that the Registrant had placed an item of medication into an unlabelled bag which she had placed in her personal bag and removed from the Pharmacy. The Committee was satisfied it was more likely than not that she had removed 56 Oxycodone 30mg tablets as alleged.

57. Allegation 2 is found proved.

Allegation 3: Your actions in relation to allegations 1 and 2 above were dishonest in that:

3.1 You did not have permission and/or authority to remove the medicines from the pharmacy.
3.2 You knew you did not have permission and/ or authority to remove items from the pharmacy.
3.3 You removed the medicines for your own use/ benefit.

58. The Committee's attention had been drawn to the test for dishonesty which was set out in the case of Ivey v Genting Casinos UK Ltd (t/a Crockfords Club) [2017] UKSC 67 which states:

> *"[74] When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. … When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people."*

59. The Committee had already found that the Registrant had removed medication from the Pharmacy without permission or authority, indeed she had admitted doing so.

60. In relation to Allegation 1, the Registrant had falsified CD and patient records to make it appear that the medication had been prescribed for Patient C, when it clearly had not. She had created dates purporting to show that Patient C had received 56 tablets of Oxycodone 20mg tablets on 22 December 2020, 2 February 2021 and 18 February 2021 when she knew this was not true given the patient's medication history. This could only have been done to enable her to remove this medication from the Pharmacy without arising suspicion because she knew she did not have permission to do so.

61. The Registrant had stated in her email of 17 March 2021 that she had put money in the Pharmacy till to pay for the drugs but there was no evidence of this. Even if she had done so, she had not obtained permission or authority to remove the medicines.

In her Disciplinary meeting on 1 April 2021, the Registrant had admitted taking the medicines for personal reasons.

62. The Committee was satisfied that an ordinary, decent person would consider the Registrant's conduct in relation to Allegation 1 to be dishonest.

63. In relation to Allegation 2, the CCTV footage clearly showed the Registrant's conduct was planned and calculated. She had taken a number of steps over a period of about 30 minutes to conceal the true nature of what she was doing. By placing a prescription in her basket before going to the CD cabinet, the Registrant had made it appear she was genuinely working on a prescription. She had then put the box containing 56 Oxycodone 30mg tablets into an unlabelled bag and left it on her bench for 20 mins or so while she continued working. She had also entered details of this medication on Patient X's records.

64. The Committee took into account the expert report from the Senior Scientist which confirmed that the testing of the Registrant's hair supported the use of Oxycodone during the period 28 September 2020 to 27 December 2020. This indicated the Registrant had personally used Oxycodone.

65. Critically, on the Registrant's first attempt to remove the unlabelled bag, she walked towards the CD cabinet room where her bag was stored but quickly turned around to go back to her bench when she realised the Pharmacy Manager was in there. This showed that she knew what she was doing was wrong and she was concealing her behaviour. A few minutes later she took the unlabelled bag back into the room containing her personal belongings when no other staff member was in the vicinity.

66. The Committee had no doubt that this behaviour demonstrated the Registrant knew what she was doing was wrong. She knew that she did not have permission or authority to remove the medication from the Pharmacy and she did so for her own benefit. The Committee was satisfied that an ordinary decent person would consider the Registrant's conduct to be dishonest.

67. Allegation 3 is found proved.

Allegation 4: On or around the following dates you falsified the controlled drug register at the Queensferry Road Branch by entering incorrect details that Patient C had been dispensed 56 x tablets of Oxycodone 20mg MR:

4.1 22nd December 2020
4.2 2nd February 2021
4.3 18th February 2021.

68. For the reasons given under Allegation 1 above, the Committee, having carefully considered the CD Register and Mr 1's evidence, was satisfied that the Registrant

had falsified the CD Register in respect of incorrect details for Patient C at the Queensferry Road Branch of the Pharmacy on the dates alleged.

69. Allegation 4 is found proved.

Allegation 5: On or around the following dates you falsified Patient C's Patient Medical Record by making an entry for 56 x tablets of Oxycodone 20mg MR:

5.1 3rd December 2020
5.2 22nd December 2020

70. The Committee had already concluded the Registrant had falsified Patient C's medical record on 22 December 2020 as set out in Allegation 1 above. Accordingly, it found Allegation 5.2 proved.

71. In relation to 3 December 2020, the Committee had considered Patient C's Medical History details in contemporaneous records produced by Mr 1. These showed an entry on 3 December 2020 for Oxycodone 20 mg tablets which did not contain a bar code. This meant that this had been a manual entry.

72. The screenshots of the CD Register did not start until 9 December 2020. The Committee did not therefore have any evidence of an entry in the CD Register, even though Patient C's dispensing record indicated in a yellow box that Patient C had apparently been prescribed 56 Longtec 20mg (the brand name for Oxycodone). The date of this was not showing in that screenshot.

73. However, the entries in the records also showed that the entry was for 14 Oxycodone 20mg tablets rather than 56 as alleged. Whilst the Committee was satisfied that it was more likely than not that a false entry had been made on Patient C's records on 3 December 2020 due to the absence of the bar code, it did not appear to be for 56 tablets as alleged, but for 14 tablets. On this basis, the Committee found Allegation 5.1 not proved.

74. Allegation 5.1 was found not proved. Allegation 5.2 was found proved.

Allegation 6: On 11th March 2021, you falsified the Controlled Drug Registers at the Tollcross Branch by entering incorrect details that Patient X had been dispensed 56 x tablets of Oxycodone 30mg MR.

75. For the reasons given in Allegation 2, the Committee was satisfied the Registrant had falsified the CD Register on 11 March 2021 to enter incorrect details for Patient X as alleged.

76. Allegation 6 was found proved.

Allegation 7: Your actions in relation to allegation 4 and 5 and 6 above were dishonest in that you knew that the entries were false and/or incorrect.

77. As Allegation 5.1 had not been proved, the Committee did not consider this any further.

78. The Committee once again considered the test in Ivey v Genting Casinos UK Ltd (t/a Crockfords Club). It also took into account the admissions made by the Registrant in her email of 17 March 2021 and during the disciplinary meeting on 1 April 2021.

79. The Registrant had made false entries in the CD Register and on Patient C's medical on 22 December 2020, 2 February 2021 and 18 February 2021. She had made false entries in the CD Register in relation to Patient X on 11 March 2021. Indeed, there was no prescription in place for Patient X for this medication on that date. These false entries were designed to mislead and imply that genuine prescriptions existed for each of those dates for each of those patients, which was not true. The Committee was satisfied the Registrant knew these entries were false as she admitted this in her disciplinary meeting and admitted she had taken the drugs for her own benefit. Indeed, when she was asked about the incident on 11 March 2021 at the Tollcross Road Branch of the Pharmacy she alerted Mr 1 to her conduct at the Queensferry Road Branch.

80. The Committee was satisfied that an ordinary decent person would consider the Registrant's conduct in relation to Allegations 4, 5.2 and 6 to be dishonest.

Allegation 7 was proved in relation to Allegation 4, Allegation 5.2 and Allegation 6.

Misconduct

81. Having found some of the Allegations proved, the Committee went on to consider whether they amounted to misconduct and, if so, whether the Registrant's fitness to practise is currently impaired.

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

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

83. The Committee took into account the submissions made by Ms Khanna. It also took into account the Registrant's emails to her employers and to the Council as well as her comments at the disciplinary meeting on 1 April 2021.

84. Ms Khanna submitted the Registrant had breached Standards 6 and 8 of the Council's Standards for Pharmacy Professionals (May 2017) ("the Standards"). She submitted the Registrant's dishonesty took place on several occasions, involving two patients over a period of 4 months. Ms Khanna submitted there had been some sophistication in the Registrant's conduct as she had identified patients with prescriptions for oxycodone and had carefully modified their records. She submitted the Registrant had not raised any concerns about her conduct until she was confronted by her employer. She submitted the Registrant's conduct amounted to misconduct.

85. The Registrant in her email of 17 March 2021 had stated she was "*ashamed*" of her behaviour and couldn't "*believe that I could do that…"* and that she was "*disgusted with myself*".

86. During the disciplinary meeting on 1 April 2021, the Registrant had read out a statement from her phone which included references to [PRIVATE] She apologised for any hurt caused. When asked about the multiple occasions on which the events had happened, the Registrant is noted to have replied: *"I did it the first time, panicked, [PRIVATE] In a way I think I wanted to get caught. My head has been mince for the last six months, I don't remember the last six months"*.

87. The Registrant was asked why she had not come forward on the first occasion, to she replied *"I thought I would be fired"*. She was asked about the pattern of the increasing strength of the medication and stated: "*I never wanted to do anything on the same strength so much, it would be more likely to be found I guess"*. As to the disposal of the drugs, the Registrant stated: *"…some went down the toilet, some went in the bucket just before it got picked up. I just put it in the bucket last thing at night so I knew it would go up".* She was asked if she had considered returning the medication for *"safe disposal"* to which she stated: *"no, for me I thought it would open up a whole new can of worms trying to put it back in the register"*.

88. The Registrant had said: "*I think I would have cracked eventually, yes"* and *"it may not have been that day but I have put extra money in the tills in Queensferry Road and Tollcross on various occasions. I asked Colleague C and Colleague D to put something through, which they may be able to verify, £10 here, £20 there."* The Registrant also asked whether she could still get her £500 NHS bonus as *"every penny counts at the moment".* She conceded she felt *"cheeky for asking"* this.

Decision on Misconduct

89. The Committee considered whether the Registrant had breached any of the Standards. The Committee determined that there had been a breach of the following Standards:

    a. Standard 1 – Pharmacy professionals must provide person-centred care. The Registrant had failed to consider the impact of her practice on Patient C and Patient X.

b. Standard 5 – Pharmacy professionals must use their professional judgement. The Registrant had failed to make the care of Patient C and Patient X her first concern or act in their best interests. She had also indicated that she was suffering from some health issues which had impacted on her behaviour. Although there was no medical evidence before the Committee, if this were true, she had practised when she was not fit to do so.

c. Standard 6 – Pharmacy professionals must behave in a professional manner. In this case the Registrant had failed to behave in a trustworthy way and had not acted honestly and with integrity.

d. Standard 8 – Pharmacy professionals must speak up when they have concerns or when things go wrong. The Registrant had not raised concerns about her health or wellbeing even though she claimed to be suffering from a number of personal problems impacting on her health. If she had had concerns which may have made her behave inappropriately, then should have mentioned it. During the disciplinary meeting on 1 April 2021, the Registrant was more concerned about losing her job although she did say that on one occasion when she was in the consulting room with her colleagues, she did think of speaking to them but she didn't want them to think "*I couldn't do it. My job was the only thing I was really good at"*.

e. Standard 9 – Pharmacy professionals must demonstrate leadership. The Registrant had been in a senior position as the Area Coordinator for the Pharmacy and had responsibility for other staff colleagues. She had failed to demonstrate leadership to those she worked with and she had abused her position which gave her access to Controlled Drugs. She had not led by example so had breached this Standard.

90. 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).

91. The Committee had found the Registrant had acted dishonestly on four occasions over a period of three months. Her conduct had been planned and she had taken steps to conceal what she was doing. The CCTV footage from the Pharmacy on 11 March 2021 showed her working efficiently but also demonstrated her knowledge and the lengths she took to achieve her aim. The footage was compelling and whilst her competence to do her job was evident, so was the fact that she was multi-tasking, thus making it was very easy for her to falsify patient records and remove the oxycodone medication without detection. Had Patient C not attended the Pharmacy on 11 March 2021, the Registrant's conduct may not have been discovered.

92. The Registrant had indicated she was "ashamed" and "disgusted" with herself which indicated she understood the gravity of her behaviour.

93. This was a case where there had been repeated dishonesty from a Registrant who was in a senior role and had access to the sensitive patient records. She was trusted and had exploited that trust in her. She had potentially placed two patients at risk by making false entries on their records, and there was no evidence that she had given any thought to the potential impact on them. There was evidence that she had been personally using this medication during the period of the first incident. The Committee had no doubt that the Registrant's conduct had fallen short of what was proper in the circumstances.

94. The Committee concluded that, in its judgement, the ground of misconduct is established.

95. The Committee therefore went on to consider whether the Registrant's fitness to practise is currently impaired.

Decision on Impairment

96. Having found that the proved Allegations amounted to misconduct, the Committee considered whether the Registrant's fitness to practise is currently impaired. In doing so the Committee considered whether the Allegations found proved show that Registrant's actions:

- *present 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*

97. The Committee considered each of these in turn.

98. The Committee found that the Registrant did present an actual risk to patients. She had not provided any evidence of remediation and her representations to her employers made no reference to the risk to patients of her behaviour. It was quite possible that another pharmacy professional could have looked at the records for Patient C and Patient X and refused future medication as the records purported to show those patients had received medication which they had not. This put their care at risk and had the potential to lead to patient harm. The Committee had no information about where the Registrant was currently working or whether she continued to have any contact with patients.

99. The Committee next considered whether the Registrant's conduct had brought or might bring the profession of pharmacy into disrepute. Pharmacy professionals are trusted to deal with Controlled Drugs in an appropriate manner. The Committee had no doubt that a member of the public would be shocked to find out that a pharmacy professional in a senior leadership role had been stealing Controlled Drugs and

falsifying patient records. The Registrant's conduct had bought the pharmacy profession into disrepute.

100. The Committee was satisfied that the Registrant had breached fundamental principles of the profession of pharmacy. The Committee had found the Registrant had breached 5 Standards which included failing to act honestly and failing to put patient care first. These were fundamental to any pharmacy professional's practice. Furthermore, by failing to act honestly, the Registrant had demonstrated her integrity could no longer be relied upon. Although she had stated to her employers that she wanted to be found out, it was clear from her calculated conduct that she had taken carefully planned steps to make sure she concealed what she was doing.

101. There was no evidence from the Registrant of remediation, training or reflective practice to address the concerns. The dishonest conduct had been repeated a number of times and other than the Registrant's admissions and expressions of remorse there was nothing to reassure the Committee the conduct would not be repeated. Her remorse was limited in any event, as the Registrant had made no reference to the impact on patients or their care, or indeed the impact on her work colleagues at any point. She had been more concerned with her own interests enquiring about whether she would receive her "*bonus*" rather than thinking about the implications on others of her behaviour. She had also given little thought to safety concerns when inappropriately disposing of Controlled Drugs.

102. These are very serious matters. The Committee had no doubt that the Registrant's fitness to practise is currently impaired for all the reasons given. It was also satisfied that a finding of impairment is needed to declare and uphold standards and maintain public confidence in the profession.

103. The Committee therefore found that the Registrant's fitness to practise is currently impaired. The Committee then considered the issue of sanction.

Decision on Sanction

104. Having found impairment, the Committee has gone on to consider the matter of sanction. The Committee's powers are set out in Article 54(2) of the Order. The Committee should consider the available sanctions in ascending order from 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.

105. 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.

106. The Committee again had regard to the Council's '*Good decision-making: Fitness to practise hearings and sanctions guidance'* to inform its decision.

107. The Committee took into account the submissions made by Ms Khanna. She drew the Committee's attention to a number of aggravating and mitigating factors and submitted the Registrant's conduct was so serious, only removal from the Register would meet public confidence in the profession and the public interest.

108. There had been limited engagement from the Registrant. Although she had mentioned health issues in her documents to her employers, there was no medical report or other independent evidence of such difficulties before the Committee.

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

110. The Committee identified the following aggravating factors:

- The Registrant's conduct had been repeated over a period of three months, it had taken place at two separate branches of the Pharmacy and had involved the falsification of two patients' records.

- There had been an element of sophisticated planning in the manner in which the Controlled Drugs were removed from the Pharmacy showing that the conduct was deliberate and premeditated.

- The Registrant had abused her position of trust. She had taken advantage of her employers. Her senior position had allowed her to have access to the medication and she had abused this by purposely stealing medication from her employer.

- There was evidence the Registrant had used a Controlled Drug, oxycodone, during the first month of her misconduct.

- The Registrant had provided no evidence of remediation and, whilst she apologised to her employers, she had shown limited remorse giving no thought to the impact on patients.

111. The Committee identified the following mitigating factors:

- The Registrant had no previous disciplinary history.

- The Registrant had made admissions to her employer, but this was only after she had been found out.

- There was no evidence of actual harm to patients.

112. It appeared the Registrant may have been suffering some personal problems at the time of the conduct but in the absence of proper engagement from her, the Committee could only place limited weight on this.

113. The Committee considered, in ascending order, each available sanction.

114. This was a very serious case involving dishonest conduct and theft. The Registrant had seriously departed from the standards expected of a Pharmacy Technician. She had had limited engagement with her regulator. The Committee had found there was a risk of repetition and the Registrant continued to present a risk to patients. She could not be trusted. In light of this the Committee was satisfied that taking no action, agreeing undertakings or issuing a warning were insufficient as they would not reflect the seriousness of the conduct or protect the public or maintain public confidence in the profession.

115. The Committee then considered whether to impose conditions on the Registrant's practice. It was clear from the Registrant's email to the Council dated 28 January 2024 that she was working but it was not known where or in what environment. In an email dated 3 September 2022 to the Council, she had stated:

> "*I work in an office and I'd rather speak with you before saying the name of the company as I really want to move on. What I can say is I'm not in pharmacy at all or front facing.*"

116. It was not known whether this was still the position but, in any event, in the absence of engagement from the Registrant, the Committee could not be sure she would comply with any conditions formulated. Furthermore, the Committee could not formulate workable conditions to address dishonesty. This was not a case where there had been poor performance or significant shortcomings which could be addressed by supervision or retraining. Therefore, the Committee concluded conditions on the Registrant's practise were not appropriate or sufficient to adequately protect the public.

117. The Committee next considered whether to suspend the Registrant from practising. It took account the gravity of the misconduct. In the absence of sufficient evidence from the Registrant of full remediation, insight, remorse or any reflection of the consequences of her conduct on patients and the public, the Committee decided that a Suspension was not the appropriate sanction. The Registrant had not satisfied

the Committee that she could be trusted as a Pharmacy Technician in the future or that she had properly addressed her dishonest conduct. The Committee concluded that a Suspension would not protect the public or be sufficient to uphold professional standards or maintain public confidence in the profession.

118. The Committee concluded that the Registrant's conduct was fundamentally incompatible with being a registered member of the pharmacy profession. She could not be trusted and her integrity could not be relied upon. A pharmacy professional is the gatekeeper of Controlled Drugs and instead of safeguarding these, the Registrant had stolen them from her employer for her own personal benefit. This is extremely serious misconduct. In the absence of sufficient evidence of remediation, insight or remorse from the Registrant, the Committee concluded that the appropriate and proportionate sanction in this case is to remove the Registrant from the Register. This is the minimum necessary to highlight to the profession and to the public that the Registrant's conduct is unacceptable and unbefitting a member of the pharmacy profession. This is also the minimum necessary to protect the public, and ensure that public trust and confidence in the profession is upheld. The Committee is satisfied that removal from the Register is the appropriate and proportionate sanction to achieve this.

119. The Committee therefore directs that the Registrar removes Sarah-Jane Forrest from the Register.

Interim Measures

120. Ms Khanna made an application for interim measures under Article 60 of the Order. Interim measures may only be imposed after an order for removal, suspension or conditions of practice. The Committee's substantive decision will not take effect until 28 days after notice of this decision has been sent to the Registrant, or until any appeal has been finally disposed.

121. Ms Khanna submitted it was necessary to protect the public and in the public interest for interim measures to take effect immediately.

122. The Committee again took account of the Council's Good decision-making Guidance (March 2017).

123. The Committee had determined the Registrant poses a risk to the public and had decided removal from the Register is required to protect the public as well as in the public interest. Having concluded the Registrant's fitness to practise is currently impaired and there is no evidence to demonstrate the Registrant has taken any steps to address the concerns, the Committee is satisfied interim measures are necessary to protect the public during any appeal period and are in the public interest.

124. The Committee grants the application for interim measures of suspension from the Register with immediate effect.

125. This concludes the determination.