General Pharmaceutical Council

Fitness To Practise Committee

Principal Hearing

Hearing held remotely by video link

15-17 January 2024

Registrant name:	Kapil Kirit Amin
Registration number:	2067994
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Julian Weinberg (Chair) Gail Curphey (Registrant member) Sara Atkins (Lay member)
Secretary:	Zainab Mohamad
General Pharmaceutical Council:	Represented by Priya Khanna, Counsel
Registrant:	The Registrant was neither present nor represented
Facts proved:	1, 2.1, 2.2, 2.3, 3, 4, 5.1, 5.2, 5.3, 6, 7
Facts proved by admission:	N/A
Facts not proved:	N/A
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 15 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.

DETERMINATION FOLLOWING A PRINCIPAL HEARING

Determination on facts

Introduction

1. Mr Kapil Kirit Amin ("the Registrant") is a Pharmacist registered with the General Pharmaceutical Council ("the Council") with registration number 2067994.

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 of these regulatory proceedings are:

   "*To protect, promote and maintain the health, safety and well-being of the public;*
   To promote and maintain public confidence in the professions regulated by the Council; and
   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. This hearing of the Council's Fitness to Practise Committee ("the Committee") has been convened to consider an allegation that the Registrant's fitness to practise as a Pharmacist is impaired by reason of misconduct. In summary, this case relates to

allegations of dishonesty or lack of integrity, arising from incidents which occurred at Salford Care Organisation (part of the Northern Care Alliance NHS Group ("the Trust")) and the (Redacted) Medical Practice ("the Practice") respectively. In respect of the former, it is alleged the Registrant failed to attend work/was absent without authorisation and failed to return a laptop to the Trust. In respect of the latter, it is alleged the Registrant received drugs, knowing or suspecting the drugs were illegal, potentially being involved in the ordering of the illegal drugs and concealing/disposing of the same. A summary of the evidence in support of the allegation is set out in the 'Background' section of this determination.

6. The Council was represented by Ms Priya Khanna. The Registrant did not attend the hearing nor was he represented.

7. The Particulars of the Allegation are as follows:

You, a Registered Pharmacist,

1. Whilst employed by the Salford Care Organisation (Northern Care Alliance NHS Group) between March and May 2019, you failed to attend work and/or you were absent without authorisation on a number of occasions.

2. Your conduct at 1 above was dishonest in that:

2.1 You knew you did not have any authorisation and/or reason to be absent from work

2.2 You did not inform any colleague and/or your employer you were absent from work

2.3 You led colleagues and/or your employer to believe you were in attendance at work.

3. On or around 18 June 2021, whilst you were working at (Redacted) Medical Practice (the "Practice") you received a package which contained a quantity of blue tablets and a white powder (the "Drugs") which you knew and/or suspected to be illegal drugs.

4. In respect of 3 above, you subsequently disposed of, and/or removed from the Practice

the Drugs without reporting it to anyone in the Practice and/or to the police.

5. Your conduct at 4 above was dishonest and/or lacking in integrity in that:

5.1 You knew and/or suspected the Drugs were illegal drugs

5.2 You were potentially implicated in the ordering or receiving of illegal drugs

5.3 You sought to conceal or dispose of evidence which implicated you in 5.1 and/or 5.2 above.

6. Subsequent to your suspension and dismissal by the Northern Care Alliance Group (the "Trust") you failed to return a Trust laptop.

7. Your conduct at 6 above was dishonest in that you knew it was not your property to keep.

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

Preliminary application

Service of Notice and proceeding in absence

8. The Registrant was neither present at the start of the hearing, nor was he represented.

9. Rule 25 of the Rules provides:

1. "*Where the person concerned is neither present nor represented at any hearing, and the Committee is satisfied that:*

(a) service of the Notice of Hearing or the Interim Order Notice has been properly effected, or

(b) all reasonable efforts have been made to serve the person concerned with Notice of Hearing or the interim order notice;

the Committee may nevertheless proceed to consider and determine the matter or allegation."

10. Accordingly, the Committee first considered whether the Registrant had been properly served with notice of this hearing.

11. Rule 16(1) of the Rules provides that where the Committee is to hold a hearing other than an interim order hearing, the secretary must serve a Notice of Hearing on the parties no less than 28 days before the date fixed for the hearing, and Rule 16(2) of the rules sets out what is required to be included in the Notice of Hearing.

12. Rule 3 of the Rules deals with service of documents. It provides:

(1) subject to paragraph (2), any notice or document required to be served by the Council under these rules must be in writing and may be served by sending it by a postal service or another delivery service (including with the agreement of the person concerned by electronic mail to an electronic address notified to the Registrar as an address for communications) or by leaving it at:

(a) in the case of a Registrant their address as entered in the register.
(b) ….
(c) ….”

(3) where any notice or document is sent on behalf of the Investigating Committee or of the [Fitness to Practise] Committee by a postal service, unless sent by a service which records the date of delivery, it must be sent by first class post and is to be treated as having been served on the day after the day on which it was posted.

(4) provides that where a notice or document has been sent by electronic mail or left at an address, it is to be treated as having been served on the day on which it was sent or left at that address.

13. The Notice of Hearing was sent to the Registrant’s registered address by first class post and by email on 8 December 2023. Having considered the contents of the Notice, the Committee is satisfied that it complied with the requirements of the Rules and that good service has therefore been effected.

14. The Committee then went on to consider whether it should exercise its discretion to proceed in the absence of the Registrant under the provisions of Rule 25.

15. The Committee accepted the advice of the Legally Qualified Chair ("LQC"). He referred the Panel to the case of *R v Jones & Hayward [2002] UKHL 5* and GMC v *Adeogba and Visvardis [2016] EWCA Civ 162*. He advised that the *Adeogba* case reminded the Panel that its primary objective is the protection of the public and the public interest. In that regard, the case of *Adeogba* stated that, "*where there is good reason not to proceed, the case should be adjourned; where there is not, however, it is only right that it should proceed*".

16. The Committee was mindful of the need to ensure that fairness and justice were maintained when deciding whether or not to proceed in the Registrant's absence. In reaching its decision it bore in mind that its discretion had to be exercised with the utmost care and caution. It weighed its responsibility for public protection and the expeditious disposal of the case against the Registrant's right to be present at the hearing.

17. The Committee was satisfied that all reasonable efforts had been made by the Council to notify the Registrant of the hearing.

18. In reaching its decision, the Panel took into account the following:

- The Registrant was sent the case papers and Listing Questionnaire on 13 June 2023 and purportedly signed for them on 23 June 2023 to which the Registrant has not responded;
- The Registrant was sent the '16 day bundle' pursuant to Rule 18 on 29 December 2023 by email to which the Registrant has also not responded;
- On 12 January 2024, the Registrant was sent the link to be able to join the hearing remotely, to which no response has been received;
- A call was made to the Registrant at 9.04 on the first morning of the hearing. The call went to voicemail and a message was left to return the call;

- The Registrant has not engaged in the regulatory process and, allegedly, repeatedly failed to meaningfully engage in the Trust's investigation process;
- The Registrant has not provided a reason for his non-attendance at this hearing;
- He has not asked for an adjournment;
- four witnesses had made themselves available to give evidence who would be inconvenienced if this hearing did not proceed; and
- There was a public interest in hearings being held expeditiously.

19. In all the circumstances, the Committee determined that it was unlikely that an adjournment would result in the Registrant's attendance at a later date. Having weighed the public interest for expedition against the Registrant's own interests, the Committee concluded that the Registrant had voluntarily absented himself and determined that it was in the interests of justice to proceed in his absence.

Application for part of the hearing to be held in private.

20. The Committee invited Ms Khanna to consider whether those parts of the hearing that relate to the health and private life of the Registrant should be held in private. Having invited representations from Ms Khanna, she agreed that such matters should properly be heard in private.

21. The Committee was aware of the public interest in regulatory hearings being held in public. This public interest is reflected in Rule 39(1) which provides that "*Except as provided for in this rule, hearings of the Committee must be held in public*." Rule 39(3)(b) provides that the Committee may hold the hearing in whole or in part in private if it "*is satisfied that the interest of the [Registrant] in maintaining their privacy outweighs the public interest in holding the hearing.....in public*."

22. Having weighed the Registrant's right to privacy regarding his health and private life against the public interest in open justice, the Committee was satisfied that the Registrant's right to privacy outweighs the public interest. The Committee was satisfied that so far as it was intended to refer to the Registrant's health or private life, that part of the hearing should be held in private.

Background

Allegations 1 and 2

23. On 14 July 2020, the Registrant received an Indefinite Final Warning from the Trust in relation to unauthorised absences and failure to attend work on several days in March and May 2019. The specific allegations considered by the Trust during the disciplinary process in respect of these matters were that there had been unauthorised absence(s)/failure to attend work on seven days in total in March and April and nine and a half-days between March and May 2019. Ms 1, who presented the matter at the disciplinary hearing, confirmed the Registrant had admitted these allegations.

24. The Trust further alleged the Registrant had misled a colleague "*into believing they were not required to attend (Redacted) Gateway to undertake their pharmacist duties, leading them to believe you had attended work and (Redacted) Gateway on Wednesday 1st May 2019 when in fact you had not*" and that "*your actions had misled the pharmacy management team in regards to your whereabouts*".

25. The Registrant provided a statement in response to these allegations, which was summarised in the Disciplinary Hearing Outcome letter of 1 August 2019 in which Ms 1 summarised the Registrant's stated position:

"...you stated you would like to apologise for your actions which you deeply regretted. You disclosed that you have been (Redacted) and that you were initially attending counselling sessions, but that you had stopped this in October 2018. You stated that you felt isolated at work and thought that when you were absent you would not be missed. You stated that you regretted that you had not raised your concerns to your manager. You confirmed that you had now taken steps to remedy the situation and you are attending counselling sessions and learning coping strategies. Additionally you feel that there is now more structure in your role. You acknowledged that your actions had caused trust issues and stated you would like the opportunity to rebuild trust".

26. As to these "*trust issues*", Ms 1 alleged at the hearing that there was "evidence" that the Registrant had "*intentionally deceived colleagues and management into believing that [he] was present in work undertaking duties when this was not the case...that [his] actions had had an impact on patient care and also on the team dynamics and reputation of the NIPPs service as a whole...that [his] actions had ultimately damaged the trust in [him] as an employee and caused a difficult relationship with a colleague*".

27. The Registrant further stated that he "*did not intend to repeat [his] actions*" and felt like his "*situation is improving*". The Registrant's reflection, together with his disclosure of his "*mental health problems*" and full attendance since the investigation in May 2019 were relevant factors which enabled the Registrant to continue in his role.

Allegations 3, 4 and 5

28. Ms 1, in her role as Lead Pharmacist of the Network Integrated Practise Pharmacy team ("NIPPS"), managed a large number of pharmacy professionals within the Primacy Care Networks in Salford. These pharmacists (and pharmacy technicians), of which the Registrant was one, were allocated to GP Practices to "*provide support relating to medicine safety*". Ms 1 explained this role "*includes supporting patients who are being transferred from hospital, medication reviews, consultations, prescribing advice, medicine safety programmes and CQC support*".

29. The Registrant was employed by the Trust to work within the NIPPS team. His role was that of a "*senior rotational pharmacist*". At the material time of the allegations, the Registrant was providing pharmacy services to the Practice.

30. Ms 2 was a Senior Receptionist at the Practice between October 2020 and March 2022. On the morning of 18 June 2021, a receptionist colleague received a package addressed to the Registrant. She passed the package on to Ms 2 at lunch time. In her role, which involved administration duties, Ms 2 was tasked with opening parcels received at the Practice "*to ensure they did not contain items that required refrigeration*". Ms 2's process would be to place the opened package in an employee's tray and then notify the employee by message that he or she needed to collect the package.

31. On receiving the package addressed to the Registrant, Ms 2 messaged him via MS Teams to collect the item. She then opened it later in the afternoon in accordance with the Practice's local policy, in the presence of the receptionist colleague who had brought the package to her.

32. Ms 2 was "*shocked at the contents*". Inside the package was a DVD case for "*The Short Sunderland Flying Boat*", partially opened, containing "*an air sanctioned packet that contained two snap bags...it was obvious due to their appearance that they were drugs. One of the snap bags contained white powder and the other contained around 15-20 blue rectangular tablets that had writing on them*". When interviewed during the local investigation into these matters in August 2021, Ms 2 explained why she believed the items in the package were drugs: "*Because there were blue tablets and white powder which would indicate it was and it was hidden*". Confirming there was no DVD in the case, Ms 2 had formed the opinion that the contents had been intentionally concealed within the DVD case. She also confirmed in her contemporaneous local statement to her employer, that the "*DVD case was not closed properly and it was very clear to see the contents. I believe the contents to be drugs*". The receptionist colleague also confirmed the DVD case was not closed.

33. Ms 2, aware the Registrant had been notified that a package had arrived for him at work, "*panicked as I knew he would be coming to the Practice and I knew this needed to be reported*". She took a photograph of the DVD case and contents to be shared with her managers. A copy of that photograph has been produced to the Committee. She then placed the package in the Registrant's tray. The latter attended the Practice in the afternoon. Ms 2 was not present when the Registrant retrieved his package from the tray. Her fellow receptionist, however, was. At around 3pm, the Registrant came "*in and out...he literally came in, took it, and went. He did look at the package but this might have been because we opened it*". Ms 2 recalls a different account of the Registrant's behaviour when attending the Practice to collect the package: "*I was not present when the Registrant collected the parcel, but my colleague [redacted] was. Due to the passage of time, I am unable to exactly recall what [redacted] told me but I do*

recall that [redacted] informed me that the Registrant was fidgeting and pretending to look for a wire or something to that effect".

34. Ms 2 reported the matter to her Practice Manager on the evening of 18 June 2021 by telephone. The Practice Manager then informed the Senior GP, Dr 1 and eventually, Ms 1.

35. On 20 June 2021, Ms 1 received an email from the Practice Manager at the Practice, requesting that she, Miss 1, contact the Practice Manager as "*a serious and concerning incident has been brought to my attention late on Friday relating to Kapil Amin which requires addressing as a matter of urgency...it really cannot be discussed over the phone and requires us to meet face to face*". On 22 June 2021, Ms 1 rang the Practice Manager, who, in turn, disclosed the Registrant had received a package at the Practice. Ms 1 was told that when parcels were received in this way, they would be opened "*in case they contained fridge items*". In her contemporaneous statement of events, Ms 1 noted: "*the Practice had received several packages that day and their policy is to open and check for fridge items as they have had an incident previously when safe storage of medicines had not been maintained*". This policy was a local one, rather than Trust wide. This policy had in fact been communicated to all staff at the Practice on 1 December 2020 by email which stated: "....*from today ALL parcels which have been delivered are to be opened, even personal ones*". It was still in place some six months later, on 28 June 2021.

36. The Practice Manager requested an in-person meeting with Ms 1, reluctant to discuss the matter further over the telephone. The in-person meeting took place on 23 June 2021 at the Practice, during the course of which the Practice Manager outlined the circumstances in which the drugs had come to be discovered. The Practice Manager, on hearing from Ms 2 on 18 June 2021, informed Dr 1, the senior GP Partner at the Practice.

37. Dr 1's role involved him running the Practice, along with the other partners, ensuring that the Practice "*fulfils its contracts and duties to the public*". He was responsible for managing employees, including the Registrant. As Dr 1 explained in his statement, "*the*

pharmacists were provided to practices to meet objectives relating to prescribing to patients as set out by the [NHS Salford Commissioning Group] and the Trust. The pharmacists can also be utilised by the practices for other matters related to prescribing. At the Practice, we utilise the pharmacists for medication reviews, reconciliation of medications from patients discharge summaries, facilitating medication searches and the monitoring of medications for the Practice population". Notably, Dr 1 confirmed that the pharmacists "*follow the policies and procedures of the Practice*".

38. On hearing about the incident from the Practice Manager, Dr 1 attempted to make contact with the Registrant at 10.30pm on 18 June 2021. He left a message on the Registrant's phone, stating he was "*concerned about the contents of the package that had been delivered to the Practice*" and requested that the Registrant contact him. A similar message was left on an alternative number for the Registrant. The Registrant did not contact Dr 1 in response to either message.

39. Dr 1 was "*surprised*" at the lack of response from the Registrant. Dr 1 stated "*the telephone calls I made to him were on the weekend, I would have thought he would have come to speak to me the first day after the weekend, which he did not do. My logical thought process was: 1. Did he receive my messages? 2. If he did, why did he not contact the surgery back? Was this deliberate or otherwise? Not returning the telephone call, on receipt, is not what I would expect from a professional but then neither is the sending of suspicious packages. If a professional is aware there could be implications to not returning such a call then as a professional or any other employee for that matter then I would have thought the employee would take steps otherwise*".

40. Dr 1 had been shown the photograph taken by Ms 2 but "*did not have clarity as to the content, not have an explanation from Kapil but did feel the manner in which it arrived looked suspicious*". Dr 1 felt the Trust, in investigating the matter, would take "*any appropriate steps they felt required*". On 21 June 2021, Dr 1 directed the Practice Manager to inform the Trust about the incident so that the latter to carry out its own

investigation. Dr 1 considered that "*if the substances were illicit then it may indicate Kapil needs help*". In the event, Dr 1 did not contact the police.

41. On 23 June 2021, Ms 1, having requested statements from Dr 1 and Ms 2 (together with requesting information about which employees had had sight of the package, details about the contents of the package and efforts to contact the Registrant by Practice staff), contacted the Associate Director of Pharmacy and an HR Advisor. The decision was made to suspend the Registrant "*pending further investigation*". This was to be communicated to the Registrant in an MS Teams meeting the same day. It was during this online meeting that the Registrant provided his account of the events leading to, including and after 18 June 2021. Ms 1 provided her account of what the Registrant said, noting that he appeared to be "*very nervous*": "*He explained that he had ordered a rare Manchester City DVD from Gumtree for his father as a Father's Day gift which at the time was on 20 June 2021. The Registrant explained that he had not expected it to arrive on 18 June 2021... When he collected the parcel from the Practice, and he found what the DVD case contained, the Registrant informed us that he attempted to contact the seller on Gumtree but that the account had been deleted... The Registrant then went on to explain that he flushed the content of the DVD...down the toilet*".

42. Ms 1 followed up this online meeting with an email, asking the Registrant to provide a statement of events, "*ideally with any supporting information like financial transactions, emails, invoices etc*". It was in the course of this communication, after the MS Teams meeting in which he had been informed he had been suspended pending further investigation, that the Registrant was asked to return his "*laptop/ IT equipment/ work phone and ID badge to the pharmacy office while the investigation is ongoing*". The Registrant was sent a "*suspension from duties letter*", dated 23 June 2021, by email on 24 June 2021. The allegation and the Registrant's account of the incident was summarised in this communication which stated: "*I informed you that I had been made aware of a package that was delivered to (Redacted) Medical Centre which was a cause for concern on Friday 18/06/21. To confirm the package was addressed to you and you collected the package that afternoon, the package had been opened by the admin team at the practice and its contents escalated...I requested that*

you send a statement, as you advised that the package wasn't what you were anticipating".

43. On 5 July 2021, the Registrant set out his statement in an email addressed to Ms 1, which provided a little more information regarding the incident:

"I was looking for a Manchester City DVD for my dad as a father's day gift and found a copy on Gumtree. I replied to the listing which requested that I contact the seller via Telegram which I did and asked that it be sent to (Redacted) Medical Centre as it was due to arrive the next day and I would not have been at home to receive it. I was initially annoyed that the wrong DVD had been sent but I was shocked when I found what appeared to be drugs in the case. I contacted the seller via telegram to ask what was going on but they never replied to my message and then later that day deleted their account."

44. This statement raised more questions for Ms 1. On 6 July 2021, she sent an email asking whether she could seek clarification from the Registrant in the following terms: "*Are we able to ask what method of payment and also for him to say what he did with the package both the dvd case and the contents*?".

45. The Registrant's suspension from the Trust was extended, on review on 4 August 2021, as the investigation into the events of 18 June 2021 continued. The investigation was carried out by Mr 1, Lead Pharmacist for the Trust, who had been instructed to do so by the Chief Pharmacist in July 2021. His role involved "*managing a team of pharmacists and pharmacy technicians providing medicines optimisation services to intermediate care and rapid response services*". His responsibilities also include "*governance of all medicines issues relevant to Community Services...this involves the production of policies, guidelines and standard operating procedures*". In this role, Mr 1 also acted as an Investigating Officer "*and investigate[s] employee disciplinary matters that may occur at any of the Trust's practices if they are not resolved locally*".

46. The process, together with the Trust's Disciplinary Procedure, has been produced to the Committee. The Investigation Report is summarised in Mr 1's witness statement. The

report includes the accounts of Dr 1, Ms 2 and Ms 1 concerning the events of and around 18 June 2021. Ms1 had noted, in her local statement as part of Mr 1's investigation, during the MS Teams meeting on 23 June 2021, that she had "*asked what Kapil had done with the contents as he also believed they were drugs. He said he had flushed them down the toilet. I did not ask about the DVD case or the packaging. I asked what Kapil had done in terms of contacting or working for the practice since that week. Kapil confirmed he had been working remotely from home and had not contacted the practice. We asked Kapil to provide a written statement of events including any information in terms of order details or payment information. Kapil did not explain why he had not felt it necessary to contact the police or alert anyone at work. Kapil did not explain why he had not returned Dr 1's telephone calls*."

47. Mr 1 observed in his conclusions on the investigation that the comment made to Ms 1 regarding the flushing of the drugs down the toilet "*has never been confirmed in writing*" [by the Registrant]. Mr 1 further noted that "*it has not been possible to determine whether they are (or are not) illegal substances*", attributing this inconclusive fact to the Registrant's choice "*not to engage with the investigation*".

48. As to the Registrant's engagement with the Trust following 18 June 2021, some communication did take place between June and September 2021. In the context of the investigation, on 3 August 2021, Mr 1 invited the Registrant to Investigatory Interview, scheduled for 12 August 2021 to take place on MS Teams. The Registrant engaged and confirmed his attendance for 12 August 2021. The link for the meeting was sent on 9 August 2021. However, on 12 August 2021, the Registrant did not attend the meeting as planned, nor did he respond to further contact made by Mr 1 on email and by telephone. On 13 August 2021, Mr 1 emailed the Registrant a letter, confirming his non-attendance on 12 August 2021 at the Investigatory Interview and inviting him to a rearranged meeting on 23 August 2021 via MS Teams. The link for the meeting was sent to the Registrant's email address and the meeting appointment was accepted by the Registrant on 17 August 2023. When asked by the Trust whether he had received the MS Teams link for the rearranged meeting, the Registrant requested, on the morning of 23 August 2021, a postponement to the following week, citing illness for the

delay. This was allowed, and a further meeting was rescheduled for the afternoon of 26 August 2021. On 26 August 2021, the Registrant emailed the Trust asking for a further postponement as he was still "*not feeling any better*". On this occasion, no further meeting was rescheduled. The Registrant was emailed on 26 August 2021, stating "*as you have failed to attend 4 investigation interviews scheduled for you, I would ask that you complete the attached questions and return by close of 2nd September to allow us to conclude the investigation*". The Registrant did not respond to that email. Mr 1 was copied into this email. A further email attaching the questions was sent to the Registrant on 9 September 2021, with a further deadline for the Registrant to respond by 13 September 2021: "...*if you wish to input into this please can I ask that the answers to the questions (attached again for your reference) are sent back*". No response was received.

49. On 16 September 2021, Ms 1 also emailed the Registrant. She had been informed by the Trust's HR department that the Registrant had not attended the meetings that had been arranged. In this email, Ms 1 asked the Registrant "*can I check if there is anything we need to be aware of? Can I also check that you have support should you wish to utilise this in terms of Union Representation*". This was followed up by a second email from Ms 1 to the Registrant, the latter not having responded to the email of 16 September 2021, on 28 September 2021: "...*can you call me please?...We are concerned because we have not been able to make any contact*...". The Registrant responded to this second communication, sending a holding email in which he stated he would call Ms 1 the following day. This he duly did by writing: "*Apologies for not replying sooner. I missed the first meeting due to a confusion over the date of the meeting. The email had one date and the teams meeting was on a different date so I joined the meeting on the wrong date. I was then ill for the second meeting which I informed them about. They subsequently sent me out a word document to fill in instead which I am yet to return to them but will do so this week. As for Union representation, I haven't sought any out so far*."

50. Despite the efforts of the Trust to arrange the investigatory interview to enable the Registrant to attend, the investigation by Mr 1 was concluded, without the Registrant's engagement, on 21 September 2021.

51. On 29 September 2021, a referral was made in respect of the Registrant, to Occupational Health, "*in case there was an underlying health concern*". Ms 1 telephoned the Registrant about this and left a voicemail informing him of the referral. The Registrant did not attend the Occupational Review meeting.

52. Following the investigation, a Disciplinary Hearing was scheduled for 12 November 2021 at which the Registrant's attendance was required. Mr 1 wrote to the Registrant about this on 21 October 2021. The Registrant did not attend the Disciplinary Hearing, which proceeded in his absence.

Allegations 6 and 7

53. Ms 1 had asked the Registrant, on 23 June 2021, to return his laptop which belonged to the Trust. This was in the context of the ongoing investigation by Trust in respect of allegations 3, 4 and 5. Following the outcome of the disciplinary matters, Ms 1 attempted to contact the Registrant by email, letter and telephone, to return the laptop. On 19 January 2022, the Registrant responded by text message, advising Ms 1 the laptop and ID badge would be duly returned the following week. The laptop (and ID badge) were not returned to the Trust. There was no further communication with the Registrant.

The Registrant's Response

54. Other than as set out in the summary given above, the Registrant has not responded to the allegations and has not provided any further statement or written reflection.

55. In advance of the hearing, the Committee had been provided with the following material, which included but was not limited to:

- Copy witness statement of Ms 1, Lead Pharmacist of the NIPPS and the Registrant's Line Manager, together with her supporting exhibits;
- Copy witness statement of Mr 1, Lead Pharmacist (Community Services) for the Trust and Investigating Officer, together with his supporting exhibits;
- Copy witness statement of Ms 2, Reception Manager at the Practice, together with her supporting exhibits;
- Copy witness statement of Dr 1, Senior Partner at the Practice, together with his supporting exhibits.

56. The Council did not call any live oral evidence but tendered their statements in evidence, having stood down their witnesses as neither the Council nor the Committee had indicated that they had any questions for them.

Findings of facts

57. In reaching its determination on the facts, the Committee has had regard to the fact that the burden of proof rests solely on the Council. It has had regard to the standard of proof as set out in the case of *Byrne v General Medical Council [2021] EWHC 2237 (Admin)* in which it was held that:

"(1) There is only one civil standard of proof in all civil cases, and that is proof that the fact in issue more probably occurred than not. (2) There is no heightened civil standard of proof in particular classes of case. In particular, it is not correct that the more serious the nature of the allegation made, the higher the standard of proof required. (3) The inherent probability or improbability of an event is a matter which can be taken into account when weighing the probabilities and in deciding whether the event occurred. Where an event is inherently improbable, it may take better evidence to persuade the judge that it has happened. This goes to the quality of evidence. (4) However it does not follow, as a rule of law, that the more serious the allegation, the less likely it is to have occurred. So whilst the court may take account of inherent probabilities, there is no logical or necessary connection between seriousness and probability. Thus, it is not the

case that "the more serious the allegation the more cogent the evidence need to prove it".

58. The Committee has also borne in mind that the fact of the Registrant's absence from this hearing does not amount to an admission of guilt and adds nothing to the Council's case. The Committee draws no adverse inference of guilt against the Registrant by reason of the fact of his absence.

Particular 1

59. The Committee found the facts proved for the following reasons.

60. The Committee has borne in mind that the Council's case relies on a summary of a statement purportedly made by the Registrant as set out in the Disciplinary Hearing Outcome letter dated 1 August 2019. The Council does not rely on copies of work attendance records or on a statement directly made by the Registrant. The Committee recognised that the Council's evidence relied on hearsay evidence, but nevertheless attributed significant weight to it given that the letter was written shortly after the meeting in question. The Committee therefore concluded that the contents of that letter could therefore justifiably be relied on as accurate.

61. However, the Disciplinary Hearing Outcome letter recorded that the Registrant had read out a statement responding to the allegations (a copy of which has not been produced to the Committee), stating that he wanted to apologise for his actions which he regretted. The letter stated that the Registrant had stated that he was not thinking rationally when taking time off work because it was inevitable that his absence would be picked up fairly quickly. In addition, he accepted that he had been absent from work as alleged, and that he thought he would not be missed. The Committee considered that it was a proper inference to draw that the Registrant, in failing to attend work, was not authorised to be absent.

62. Mindful that the burden of proof rests on the Council, the Committee noted that the Registrant has not challenged the contents of the Disciplinary Hearing Outcome letter or advanced a defence to the allegation. In the circumstances, the Committee

concluded that the contents of the letter accurately reflected what the Registrant had said in the disciplinary hearing.

63. The Committee therefore found the facts of Particular 1 proved.

Particular 2

Particular 2.1

64. The Committee found the facts proved for the following reasons.

65. For the reasons set out in paragraph 61 above, the Committee concluded that the Registrant did not have authorisation to be absent from work. The Committee noted that the Registrant made reference to health reasons for being absent. The Committee concluded that even if the Registrant had a legitimate health reason for being absent, he nevertheless knew that his absence was not authorised. As a matter of fact, the Committee noted that the Registrant has not produced any medical records that might otherwise evidence that he was entitled to be off work for health reasons.

66. The Committee therefore found the facts of sub-Particular 2.1 proved.

Particular 2.2

67. The Committee found the facts proved for the following reasons.

68. For the reasons set out in paragraph 61 above, the Committee further concluded that it was a proper inference to draw that the Registrant had not informed a colleague or his employer that he was absent from work. It is not suggested that he disputed this specific allegation against him at the time of the disciplinary hearing, nor has the Registrant subsequently advanced a defence to the allegation.

69. The Committee therefore found the facts of sub-Particular 2.2 proved.

Particular 2.3

70. The Committee found the facts proved for the following reasons.

71. This allegation was set out in the Disciplinary Hearing Outcome letter as a reason for a disciplinary investigation being required. As set out earlier in this determination, the Registrant is stated to have apologised for his actions. It is not suggested that he disputed this specific allegation against him at the time of the disciplinary hearing, nor has the Registrant subsequently advanced a defence to the allegation.

72. In the circumstances, the Committee concluded that it was a proper inference to draw that the Registrant led colleagues and/or his employer to believe that he was in attendance at work when he was not.

73. The Committee therefore found the facts of sub-Particular 2.3 proved.

74. Having found the facts of sub-Particulars 2.1, 2.2 and 2.3 proved, the Committee then went on to consider whether the Registrant was dishonest as alleged.

75. In considering whether the respondent acted dishonestly, the committee has applied the test for dishonesty as set out in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67*:

"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. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. 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. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest."

<u>Dishonesty in relation to Particular 1</u>

76. The Committee has found that the Registrant was absent from work when he knew that he was not authorised to be absent, had not informed colleagues/his employer that he was absent, and led colleagues/his employer to believe that he was at work.

77. The Panel concluded that ordinary members of the public would consider that being absent in those circumstances, would be considered dishonest.

78. The Panel therefore concluded that the Registrant's conduct in relation to Particular 1 was dishonest by reason of those matters found proved at Particulars 2.1, 2.2 and 2.3.

79. The Panel therefore found Particular 2 proved.

Particular 3

80. The Committee found the facts proved for the following reasons.

81. Given its consistency with the documented exhibits, the Committee considered and accepted the written evidence of Ms 1 and Ms 2 as being reliable, and having seen a copy of a photograph of the package that arrived, addressed to the Registrant, the Committee is satisfied that the Registrant received a package containing a quantity of blue tablets and white powder at the Practice.

82. The Committee noted the contents of the Registrant's email dated 5 July 2021 in which he stated: "*I was initially annoyed that the wrong DVD had been sent but I was shocked when I found what appeared to be drugs in the case*". In the circumstances, the Committee was satisfied that the Registrant knew or suspected the package to contain illegal drugs.

83. The Committee agrees with the Council's submission and was further supported in reaching that conclusion, by reason of the following:

- The Registrant's failed to respond to his employer's voicemail messages about the package on 18 June 2021;

- The manner in which the Registrant disposed of the drugs, namely by the Registrant admitting that he flushed them down the toilet, giving rise to a strong inference that he was destroying evidence in order to conceal the true nature of the items disposed of;
- The DVD that had in fact been sent to the Registrant was called "The Short Sunderland Flying Boat", when the Registrant stated that he had ordered a Manchester City DVD. Despite this, the Registrant left with the package from work;
- The Registrant, an experienced pharmacist in a role of significant responsibility, did not either appropriately safely dispose of them, or bring the powder or tablets back to work for them to be safely disposed of;
- The Registrant's failure, despite being asked, to furnish purchase or invoice details relating to the acquisition of the DVD;
- The Registrant's failure to report the matter of his own volition to the police or his employer;
- The Registrant would not have received legitimate drugs for himself in that manner. If the drugs were legitimate, they would have been packaged and marked in the usual way.

84. The Committee therefore found the facts of Particular 3 proved.

Particular 4

85. The Committee found the facts proved for the following reasons.

86. The Committee has had regard to the contents of Ms 1's statement of events dated 23 June 2021, notes that were made relatively contemporaneously to the events in question. In her notes, she stated:

"*Kapil replied to say he had ordered a rare Man City DVD from Gumtree and that he was not expecting what arrived. He confirmed that the parcel was addressed to himself and that he came into the practice to collect it that Friday afternoon. Kapil said he tried to contact the sender but they deleted their account from Gumtree.*

I asked what Kapil had done with the contents as he also believed they were drugs. He said he had flushed them down the toilet. I did not ask about the DVD case or the packaging. I asked what Kapil had done in terms of contacting or working for the practice since that week.

Kapil confirmed he had been working remotely from home and had not contacted the practice. We asked Kapil to provide a written statement of events including any information in terms of order details or payment information.

Kapil did not explain why he had not felt it necessary to contact the police or alert anyone at work. Kapil did not explain why he had not returned Dr 1's telephone calls."

87. Mindful that the burden of proof rests on the Council, the Committee noted that the Registrant has neither advanced a defence to the allegation, nor challenged Ms 1's recollection of events. The Committee concluded that Ms 1's reference to a Manchester City DVD was consistent with a similar reference by the Registrant in his email of 5 July 2021. The Committee therefore concluded that Ms 1's evidence in relation to the Registrant's admission to her that he flushed the items in question down the toilet, and that he had not reported the matter, could be relied upon.

88. The Committee therefore found the facts of Particular 4 proved.

Particular 5

Particulars 5.1, 5.2 and 5.3

89. The Committee found the facts proved for the following reasons.

90. The Committee repeats its rationale as set out at paragraph 83 above. It also agrees with the submissions advanced by Ms Khanna on behalf of the Council. The Committee has had regard to the manner in which the drugs arrived in the package, concealed within a DVD, addressed to the Registrant. The Committee concluded that it was a proper inference to draw that the Registrant was aware of the true nature of the items. The Committee has also borne in mind the Registrant's disposal of the Drugs, as found in relation to Particular 4, by flushing them down the toilet. The Committee was

mindful that as a Pharmacist, the Registrant would have been aware of legitimate ways of disposal of the Drugs that were available to him, for example, by putting the Drugs in a medication disposal bin at the Practice, or by handing the Drugs to the police, as opposed to taking the Drugs from the Practice and flushing them down the toilet.

91. The Committee therefore found sub-paragraphs 5.1, 5.2 and 5.3 proved.

Dishonesty / lack of integrity in relation to Particular 4

92. The law on integrity and its relationship with dishonesty was set out in the Court of Appeal case of *Wingate v Solicitors Regulation Authority [2018] EWCA Civ 366* in which the following characteristics of integrity were identifed:

"(a) "Integrity" connotes moral soundness, rectitude and steady adherence to an ethical code (paragraph 66, referring to the case of Hoodless);
(b) Integrity is a broader concept than honesty (paragraph 95);
(c) Integrity is a more nebulous concept than honesty (paragraph 96);
(d) The term "integrity" is a useful shorthand to express the higher standards which society expects from professional persons and which the professions expect from their own members. The underlying rationale is that the professions have a privileged and trusted role in society. In return they are required to live up to their own professional standards (paragraph 97);
(e) Integrity connotes adherence to the ethical standards of one's own profession. That involves more than mere honesty (paragraph 100);
(f) A professional disciplinary tribunal has specialist knowledge of the profession to which the respondent belongs and of the ethical standards of that profession. Accordingly such a body is well placed to identify want of integrity (paragraph 103)."

93. The Committee has found that the Registrant removed the Drugs from the Practice and subsequently disposed of them without reporting it, knowing/suspecting that the Drugs were illicit drugs and that he was implicated in ordering/receiving them.

94. The Panel concluded that ordinary members of the public would consider that that concealing or disposing of illegal drugs in those circumstances, would be considered dishonest.

95. So far as a lack of integrity is concerned, the Committee concluded that, given the Registrant's responsibility to ensure medications are managed safely and disposed of appropriately, had he been acting with integrity, the Registrant would not have concealed the Drugs or flushed them down the toilet.

96. Being open and transparent and acting with candour are essential qualities of what is required of a professional. By acting as found proved at Particulars 4 and 5, and in frustrating the investigation process, the Registrant's conduct amounted to a breach of his professional responsibility to act with integrity.

97. The Panel therefore concluded that in relation to this Particular, the Registrant acted dishonestly and without integrity. The Panel therefore found this Particular proved in respect of Particular 4.

Particular 6

98. The Committee found the facts proved for the following reasons.

99. The Committee has noted and accepted the evidence of Mr 1 who stated that following the Disciplinary Hearing on 12 November 2021, the hearing went ahead in the Registrant's absence and that the Registrant was subsequently dismissed from the Trust.

100. The Committee has had sight of an email dated 21 June 2021 from Ms 1 to the Registrant in which she asks him to return his laptop which belonged to the Trust given the ongoing Trust investigation into the matters alleged at Particulars 3-5. Given that the laptop was not returned, Ms 1 made further attempts to contact the Registrant for its return.

101. The Committee has had sight of copies of text messages dated 19 January 2022 between Ms 1 and the Registrant which read as follows:

"*Hi Kapil, please can you contact me to return your laptop and ID badge. We currently have a shortage of laptops and really need to pass this on. Many thanks….*

In response, the Registrant texted:

'*Hi Ms 1 I'm in London for a couple of weeks. I shall drop them off at the end of next week*".

102. Ms 1 stated, and the Committee accepts, that the laptop was not returned when he had an obligation to do so.

103. The Committee therefore found the facts of Particular 6 proved.

Particular 7

104. The Committee found the facts proved for the following reasons.

105. By reason of its finding in relation to Particular 6, the Committee has found that, having been dismissed by the Trust, the Registrant failed to return a laptop belonging to his former employer, which he knew he was not entitled to retain, despite having been asked to return it and having agreed to do so.

106. The Panel concluded that ordinary members of the public would consider that continuing to retain the laptop and failing to return it to the Trust, knowing that he was not entitled to retain it, and having agreed to return it, would be considered dishonest.

107. The Panel therefore concluded that in relation to this Particular, the Registrant acted dishonestly. The Panel therefore finds this Particular proved in respect of Particular 6.

108. The Committee therefore found the facts of Particular 7 proved.

Misconduct and Impairment

Misconduct

Council's submissions

109. Ms Khanna, made oral submissions and also relied on written submissions in a further combined case statement and skeleton argument dated 20 December 2023. She reminded the Committee to take a two-stepped approach, firstly to consider whether the Registrant's actions amounted to misconduct, and if so, to then consider whether his fitness to practise was currently impaired. She referred the Committee to the case of *Roylance v General Medical Council (No. 2) [2000] 1AC 311* in which misconduct was described as:

"*Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed... in the particular circumstances….A falling short by omission or commission of the standards to be expected among [medical practitioners] and such falling short must be serious*".

110. She also referred to the case of *R (on the Application of Remedy UK) v GMC [2010] EWHC1245 (Admin),* which clarified that:

"*Misconduct is of two principal kinds. First, it may involve sufficiently serious misconduct in the exercise of professional practice … Secondly, it can involve conduct of a morally culpable or otherwise disgraceful kind which may occur outwith the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession.*

Misconduct within the first limb need not arise in the context of a doctor exercising his clinical practice, but it must be in the exercise of the doctor's medical calling. There is no single or simple test for defining when that condition is satisfied.

Conduct falls into the second limb if it is dishonourable or disgraceful or attracts some kind of opprobrium; that fact may be sufficient to bring the profession of medicine into disrepute. It matters not whether such conduct is directly related to the exercise of professional skill".

111. Ms Khanna submitted that the Registrant's conduct fell within the first limb of *Remedy*.

112. Ms Khanna invited the Committee to conclude that the Registrant's actions breached the following provisions of the Council's *Standards of conduct, ethics and performance (2017)* ("the 2017 Standards").

Standard 6: Pharmacy professionals must behave in a professional manner
Standard 8: Pharmacy professionals must speak up when they have concerns or when things go wrong

113. Ms Khanna submitted that in relation to Standard 6, the standard requires that pharmacy professionals are trustworthy and act with honesty and integrity. The Registrant's dishonesty and or lack of integrity was not limited to one occasion or one incident; in fact, the conduct endured over a long period of time, bookended by disciplinary hearings by his employer: 2019 (absences from work), 2021 (drugs in the workplace) and 2022 (dishonest retention of the laptop).

114. In relation to Standard 8, she submitted that this standard requires a Pharmacy Professional to "*raise a concern, even when it is not easy to do so*", "*to promptly tell their employer and all relevant authorities (including the GPhC) about concerns they may have" and to be "open and honest when things go wrong*". She submitted that the Registrant has displayed a flagrant disregard for this Standard. On realising the package, which contained the Drugs, had been received and opened by his employer, the Registrant should have raised the concern. Had he acted honestly or with integrity, this would have happened naturally, notwithstanding how difficult it might have personally been for the Registrant to do so. Instead, the Registrant remained silent and did not respond to his employer's answerphone messages to raise the concern that drugs were in the DVD. There was a complete absence of prompt reporting that things

had gone wrong. In fact, the police were not notified by the Registrant, something which would have been immediately obvious to a professional who received visibly suspicious items contrary entirely to the order they claim they had genuinely placed. Such a professional would not have destroyed evidence of this type or significance. The Registrant, she submitted, was anything but open and honest when things had gone wrong. This applied equally with his disregard over the return of the laptop. If anything, the text message he sent agreeing to the return of the items was quite contrary to his stated intention.

115. The breach of the Standards detailed above demonstrated that the Registrant has breached fundamental principles of the pharmacy profession. Complying with legal and professional requirements is of central importance to the pharmacy profession. It is submitted that as the Registrant breached this, it is considered that his integrity can no longer be relied upon. She referred the Committee to the 'test' for integrity as referred to in the case of *Wingate*.

116. She further submitted that the wider public interest related not only to maintaining confidence in the pharmacy profession, but also in maintaining confidence in the regulator who must uphold the proper standards of behaviour and conduct. The Registrant held a privileged position in society that should encourage trust and confidence. She therefore submitted that the Registrant's conduct fell far below the standards expected of Pharmacy professionals and amounted to misconduct.

Impairment

117. Ms Khanna referred the Committee to Rule 5(1) of the Rules which states that the Committee should have regard to the criteria specified at paragraph 5(2) of the Rules which states:

"In relation to evidence about the conduct or behaviour of the Registrant which might cast doubt on whether the requirements as to fitness to practise are met in relation to the Registrant, the Committee must have regard to whether or not that conduct:

(a) presents an actual or potential risk to patients, or to the public;

(b) has brought, or might bring, the profession of pharmacy into disrepute;

(c) has breached one of the fundamental principles of the profession of pharmacy; or,

(d) shows that the integrity of the Registrant can no longer be relied upon."

118. She referred the Committee to principles derived from the cases of *Cheatle v GMC EWCA Civ 1390 [2007] 1 QB 462* and *Cohen v GMC [2008] EWHC 581 (Admin).*

119. Ms Khanna submitted that a finding of current impairment was necessary in order to maintain public confidence in the pharmacy profession. She reminded the Committee of the observations of Mrs Justice Cox in the case of *CHRE v NMC and Grant [2011] EWHC 927 (Admin)* in which it was said:

"In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances."

120. Ms Khanna submitted that when considering whether the Registrant's current fitness to practise is currently impaired, the Committee should take into consideration the need to maintain public confidence in the profession in addition to maintaining proper standards of conduct.

121. She stated that the Council's case was that Rule 5(2)(a), (b), (c) and (d) were all engaged, together with the observations in *Grant* in this matter. She submitted that this is a case where protection of the public from a risk harm was a relevant consideration. This case involved unpredictable and frequent absences from work without authorisation, putting patients' needs and medicinal care in jeopardy. Furthermore, there was a direct risk of harm to patients by allowing or enabling illicit drugs to come into the Practice, where packages were known to be opened, in case they contained medication that required refrigeration. An inexperienced staff member could have, unknowingly,

placed the drugs where they could have been accessed by (potentially) several unsuspecting people, including members of the public.

122. She submitted that the Council has evidenced a series of events involving the Registrant, over the course of three years, which are serious. There was evidence of a propensity to behave dishonestly and without integrity such that would justify a wider finding of impaired fitness to practise.

123. There is a focus also on the wider public interest in declaring and upholding standards and in maintaining public confidence in the profession. Any misconduct that is deemed to be dishonest and or lacking in integrity has the potential to bring the profession into disrepute. The Registrant was an experienced and important member of the Team at the Practice and the Trust. His actions in lying to his employer, concealing and destroying evidence and dishonestly retaining his employer's property clearly bring the profession into disrepute. She submitted that the Registrant, by his actions, has breached the standards of the profession, namely Standards 6 and 8. The behaviour demonstrated by the Registrant is damaging to the reputation of the profession and has a detrimental effect on public confidence in the pharmacy profession.

124. She reminded the Committee that the Registrant has not engaged fully with the Council's investigation. He has not provided evidence of reflection or insight into his behaviour. His position in respect of the allegations is therefore unknown. The Registrant has not provided references or any testimonials. There is no evidence of remediation of his conduct before the Committee. There is no evidence of training and or supervision. In view of this, the risk of repetition of the same misconduct in the future remains high. The conduct raises public interest considerations. She therefore submitted that a finding of impairment was necessary to uphold standards and public confidence in the profession.

125. The case of *Cohen*, she submitted, is a reminder of the importance of remediation. Dishonesty and or a lack of integrity demonstrates a serious attitudinal shortcoming which is difficult to remediate. In terms of remediation, training and/or supervision, are, in any event, unlikely to address these concerns.

126. She therefore submitted that a finding of current impairment is necessary to uphold confidence in the Council as a Regulator and in the profession and she invited the Committee to make that finding in this case.

Submissions made on behalf of the Registrant

127. No specific submissions in relation to misconduct or impairment have been received by, or on behalf of the Registrant. The Committee has however noted the Registrant's apology referred to in the Disciplinary Hearing Outcome letter of 1 August 2019 referred to at paragraph 25 above, being relevant to the underlying facts of Particulars 1 and 2.

The Committee's decision on misconduct and impairment

128. Article 51 of the Pharmacy Order 2010 provides that a person's fitness to practise is to be regarded as impaired by reason of one or more of a number of circumstances. These include, at (a), 'misconduct'.

129. The Committee first considered whether the Registrant's actions, as found proved, amounted to misconduct. The Committee recognised that in reaching its findings in respect of misconduct and impairment, there is no burden or standard of proof to be applied, but that it was a matter for the Committee to determine, exercising its independent judgment.

130. The Committee had regard to the case of *Roylance* in which it was said that:

Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a … practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word 'professional' which links the misconduct to the profession ... Secondly, the misconduct is qualified by the word 'serious'. It is not any professional misconduct which will qualify. The professional misconduct must be serious."

131. The Committee first considered whether there has been misconduct on the part of the Registrant.

132. The Committee recognised that for a finding of misconduct to be made, the Registrant's conduct would have to amount to a serious falling short of the standard expected of him. The kind of serious misconduct required was described in the case of *Nandi v GMC [2004] EWHC 2317 (Admin)* and *Meadow v GMC [2006] EWCA Civ 1390* as: "*a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be serious" such that it would be "regarded as deplorable by fellow practitioner*s".

133. In the case of *GMC v Igwilo [2017] EWHC 419 (Admin),* it was held that dishonesty constitutes a breach of a fundamental tenet of the profession. The case of *Patel v GMC Privy Council Appeal No.48 of 2002* determined that dishonesty was at the top end of the spectrum of the gravity of misconduct.

134. The Committee concluded that the Registrant's dishonest conduct, could quite properly be categorised as a serious breach of Standards 6 and 8.

135. As set out in its determination on the facts, the Committee has found that the Registrant repeatedly behaved dishonestly, particularly in disposing of the Drugs. Such conduct unquestionably fell seriously short of a Pharmacist's obligations in relation to drug management and disposal.

136. Furthermore, in dishonestly absenting himself from work, as Ms 1 stated, the Registrant's actions *"intentionally deceived colleagues and management into believing that [he] was present in work undertaking duties when this was not the case...that [his] actions had had an impact on patient care and also on the team dynamics and reputation of the NIPPs service as a whole...that [his] actions had ultimately damaged the trust in [him] as an employee and caused a difficult relationship with a colleague*".

137. Such conduct, the Committee concluded, also amounted to conduct falling seriously short of the standard expected of the Registrant.

138. Similarly, the Committee concluded that by dishonestly retaining a laptop when required to return it, the Registrant's conduct fell seriously short of the standard expected of him.

139. In the circumstances, the Committee found that the Registrant's dishonest conduct found proved, both individually and collectively, fell sufficiently far short of the standard expected of him that it amounted to misconduct.

140. In relation to impairment, following the decisions in *GMC v Choudhary* and *GMC v Nwachuku [2017] EWHC 2085 (Admin)*, the Committee is mindful that it does not necessarily follow that a finding of current impairment must be made. However, it will be an unusual case where dishonesty is not found to impair fitness to practise *PSA v HCPC & Ghaffar [2014] EWHC 2723 (Admin*). It is accepted that dishonesty encompasses a very wide range of different facts and circumstances, but that any instance of it is likely to impair a professional person's fitness to practise *R (Hassan) v General Optical Council [2013] EWHC 1887*.

141. The Committee noted the guidance given on the meaning of 'fitness to practise' in the Council's publication *Good decision-making (revised March 2017)*. At paragraph 2.11, the guidance states:

"A pharmacy professional is 'fit to practise' when they have the skills, knowledge, character, behaviour and health needed to work as a pharmacist or pharmacy technician 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 our various standards, guidance and advice".

142. There is no statutory definition of what amounts to impairment of fitness to practise. However, the Committee has had regard to Rule 5(2) of the Rules (set out above) which

mirrors the comments of Mrs Justice Cox in the case of *CHRE v NMC and Grant [2011] EWHC 926 (Admin).*

143. Principles in relation to honesty and integrity of *Standards of Conduct, Ethics and Performance* are fundamental principles of the pharmacy profession and are essential qualities to be expected of a Pharmacist if public confidence in the profession is to be maintained. In addition, dishonestly absenting oneself from work, thereby imposing an additional burden on colleagues has the potential to cause patient harm by unnecessarily stretching resources. The Committee therefore found the breaches of that principle engaged paragraphs (a), (b), (c) and (d) of Rule 5(2).

144. In the case of *Cohen v General Medical Council [2008] EWHC 581 (Admin)*, it was noted that when considering the question of impairment, the Committee should give appropriate weight to the public interest, including the protection of the public, the maintenance of public confidence in the profession and upholding proper standards of conduct and behaviour. The Committee is mindful that it is relevant to consider whether the conduct is easily remediable, whether it has been remedied and whether it is highly unlikely to be repeated. The Committee notes that the questions posed in the *Cohen* case are not a test in which the answers determine the question of impairment, but are a part of the analysing process to be undertaken.

145. The Committee accepted that whilst dishonest behaviour is potentially remediable, it is difficult to do so.

146. The first step towards remediation would be to show insight, which would involve demonstrating reflection and accepting wrongdoing. Such insight, if shown, reduces the risk of repetition of similar behaviour. In considering insight and the risk of repetition, the Committee noted that the Registrant has not provided any evidence whatsoever regarding his current circumstances, including in relation to his health, to demonstrate that he has developed a meaningful level of insight or that he has taken steps to address his dishonest behaviour.

147. Therefore, in all the circumstances, the Committee concluded that, whilst the Registrant's failings were potentially capable of remediation, it could not conclude that his failings had been remediated. It determined that, in all the circumstances, there was a significant risk of his dishonest misconduct being repeated and therefore a significant ongoing risk of harm to the public. In the circumstances, the Committee found that the Registrant's fitness to practise is currently impaired on public protection grounds.

148. The Committee has taken into account that the Registrant behaved dishonestly in the course of his work. The Committee considered that the Registrant's actions will have had a negative impact on public confidence in the pharmacy profession and would bring the profession into disrepute.

149. Given the seriousness of the misconduct found proved, the Committee is satisfied that a finding of impairment is required to uphold proper professional standards and public confidence in the profession, as failure to do so would undermine that confidence.

150. The Committee has also taken account of the overarching objective of fitness to practise proceedings in that it should consider, not only the need to protect the public, but the need to uphold the reputation of the profession and to declare and uphold proper standards of conduct and behaviour. In doing so, the Committee has borne in mind the comments of Mrs Justice Cox in the case of *Grant*, in which she said:

"In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances."

151. Given the nature and seriousness of the misconduct found proved, the lack of demonstrable insight, and the identified ongoing risk of harm to the public identified, the Committee is satisfied that a finding of impairment is also required to uphold proper

professional standards and that public confidence in the profession would be undermined if no such finding were made.

152. For these reasons, the Committee concluded that the Registrant's fitness to practise as a Pharmacist is also currently impaired by reason of his misconduct on public interest grounds.

Sanction

Council's submissions

153. The Committee first heard submissions from Ms Khanna. She referred to her written skeleton argument regarding how the Committee should approach this stage of the hearing.

154. Ms Khanna reminded the Committee of its powers as set out in Article 54(2) of the Pharmacy Order which provides:

"*If the Fitness to Practise Committee determines that the person concerned's fitness to practise is impaired, it may–*
(a) give a warning to the person concerned in connection with any matter arising out of or related to the allegation and give a direction that details of the warning must be recorded in the register,
(b) give advice to any other person or other body involved in the investigation of the allegation on any issue arising out of or related to the allegation;
(c) give a direction that the person concerned be removed from the register;
(d) give a direction that the entry in the Register of the person concerned be suspended, for such period not exceeding 12 months as may be specified in the direction; or
(e) give a direction that the entry in the Register of the person concerned be conditional upon that person complying, during such period not exceeding 3 years as may be specified in the direction, with such requirements specified in the direction as the Committee thinks fit to impose for the protection of the public or otherwise in the public interest or in the interest of the person concerned."

155. She reminded the Committee to have regard to the need to protect the public, to maintain public confidence in the profession and to maintain proper standards of conduct.

156. She reminded the Committee to have regard to the Council's Good decision making: Fitness to practise hearings and sanctions guidance. In doing so, she identified the aggravating factors for the Committee to take into account:

a) The Registrant's conduct took place in a Trust and GP setting;
b) As the gatekeeper of medications, the Registrant enabled illicit drugs to be brought into a GP Practice;
c) The Registrant destroyed the evidence of the Drugs to conceal their true nature, rather than dispose of them in a proper, professional manner;
d) The Registrant had already been subject to disciplinary proceedings by his employer where questions over his integrity and honesty had been raised. It is against this background that the Registrant acted dishonestly on not one, but two further occasions in respect of his employers; and
e) The Registrant did not engage in the investigation and disciplinary process with his employer in 2021. He has been equally derelict in engaging with these current regulatory proceedings.

157. By way of mitigating factors, she identified:

a) The Registrant made admissions in 2019 to his employer in respect of the factual matters underpinning Allegation 1.

158. Ms Khanna informed the Committee that in relation to the Registrant's previous regulatory history:

- In April 2013, the Registrant received a warning from the Investigation Committee following a conviction for drink driving; and
- In August 2015, the Registrant was given advice in relation to his failure to obtain consent prior to a medication review.

159. Ms Khanna recognised, in informing the Committee of these matters, that they related to matters of a different nature to the matters before this Committee, and related to events many years ago.

160. In relation to sanction, Ms Khanna submitted that only a removal from the Register would be meet the public confidence and public interest considerations. She submitted that these incidents were part of a pattern of behaviour, which have persisted unabated for over three years. She submitted that there was not any evidence of remediation or insight by the Registrant. This, she submitted, was a case of serious and repeated dishonesty and an enduring lack of integrity. In light of this, she submitted that removal was the appropriate and proportionate measure in this matter. The real and tangible risk of repetition and of future harm to the public, she submitted, necessitated the most serious sanction.

Registrant's submissions

161. The Registrant had not provided any representations or documentation in mitigation.

Decision on sanction

162. The Committee has paid due regard to its powers under Article 54(2) of the Pharmacy Order 2010 and the Council's "Good decision making: Fitness to practise and sanctions guidance" in considering its approach to its determination on sanction, having particular regard to those parts of the Guidance dealing with dishonesty and a Registrant's duty of candour (paragraphs 6.8-6.13).

163. The Committee then considered whether to impose a sanction, and if so, which one. The Committee has had regard to the public interest, which includes the need to protect the public, to maintain confidence in the profession and to declare and uphold proper standards of conduct and behaviour. The Committee has carefully considered all the evidence and submissions made during the course of this hearing. It has borne in mind that the purpose of imposing a sanction is not to be punitive although it may have a

punitive effect. It has taken into account the Registrant's interests and the need to act proportionately, in other words, that the sanction should be no more serious than it needs to be to achieve its aims. It has taken into account any aggravating and mitigating factors identified. The Committee has exercised its own independent judgement. In considering which sanction to impose, the Committee started by considering the least restrictive sanction, and whether that is appropriate, and if not, continuing until the appropriate and proportionate sanction is reached.

164. The Committee has reminded itself of the principal derived from the case of *Bolton v Law Society [1991] 1 WLR 512 CA* in which it was said that:

"The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is part of the price."

165. The Committee has borne in mind that it was held in the case of *GMC v Armstrong [2021] EWHC 1658 (Admin)* that the impact on public confidence in cases involving dishonesty, in particular in a regulatory regime, is not diminished even where the practitioner in question is unlikely to repeat their dishonesty.

166. The Committee was mindful that: "*The effect of dishonesty by professionals as far as public confidence in the public is concerned….is a primary consideration for a Fitness to Practise panel*": *Siddiqui v GMC [2013] EWHC 1883 (Admin).* It has also borne in mind the principle from the case of *PSA v Nursing and Midwifery Council, Mr D Wilson [2015] EWHC 1887 (Admin)* where it was held that the public interest outweighs the Registrant's interest, and the effect of sanction on a registrant was very much of secondary importance. In that case, it was said that: "*The overriding factor ... was the public interest in maintaining the reputation of the profession. The [NMC] and the public are entitled to the highest standards of honesty and integrity from the Registrants...*"

167. In considering the sanction appropriate in this case, the Committee first gave consideration to the mitigating and aggravating features identified.

168. It identified the following aggravating factors:

- The Registrant's dishonesty was deliberate and repeated over a three year period;
- The Registrant was in a position of trust within the Practice and the Trust;
- In relation to Particulars 3-5, the Registrant demonstrated a deliberate lack of candour in that he failed to engage with the Trust in its investigation regarding the Drugs, was obstructive, and his actions inevitably frustrated the investigation process;
- As set out earlier in its determination on impairment, the Registrant has not demonstrated any meaningful insight into his failings, nor demonstrated that he taken steps to remediate his misconduct;
- He has not engaged in the regulatory process.

169. The Committee has not identified any mitigating factors save for his admission in 2019 to his employer in respect of the factual matters underpinning Allegation 1, identified by Ms Khanna. The Committee noted that the Registrant has not provided any references or testimonials, nor has he provided any medical evidence that any health condition might have impacted on his conduct.

170. The Committee is mindful that it is incumbent on any Registrant to ensure that they comply with their professional obligations. However, the Committee considered that, having been investigated twice by his regulator, albeit several years ago and for unrelated matters, the Registrant should have had a heightened awareness of the need to fully comply with the Council's professional standards.

171. The Committee has borne in mind that care should be taken to determine, where, on a properly nuanced scale of dishonesty, the misconduct falls: *Lusinga v NMC [2017] EWHC 1458 (Admin)* and *Watters v NMC [2017] EWHC 1888 (Admin)*. Having considered the above, and particularly taking into account the repeated nature of the Registrant's dishonesty directed towards two separate employers, the Committee concluded that the Registrant's dishonesty, taken in the round, fell towards the upper end of the spectrum of dishonesty.

172. The Committee first considered taking no action but considered that, given the aggravating factors in this case and the identified ongoing risks, taking no action would therefore be insufficient to protect the public and the public interest or uphold confidence in the profession as such an outcome would not restrict the Registrant's practice in any way. Such an outcome would not involve any public marking of this Committee's findings and was therefore neither an appropriate nor proportionate sanction to impose.

173. The Committee then considered imposing a Warning. Such an outcome may be appropriate where there is a need to demonstrate to a Registrant, and to the wider public, that the Registrant's conduct fell below acceptable standards. It may also be appropriate where there is no continuing risk to the public and where there is need for there to be a public acknowledgement that the conduct was unacceptable.

174. The Committee considered that, given the aggravating factors and the ongoing risks identified, the Registrant's misconduct, which related to repeated dishonest behaviour, was too serious for such an outcome. Imposing a warning, would fail to sufficiently address the public protection and public interest concerns identified as the Registrant's practice would not be subject to any restriction.

175. The Committee next considered whether to impose a period of conditional registration. The Committee noted that the sanctions guidance indicates that conditions may apply where:

"There is evidence of poor performance, or significant shortcomings in a Registrant's practice, but the committee is satisfied that the Registrant may respond positively to retraining and supervision.
There is not a significant risk posed to the public, and it is safe for the Registrant to return to practice but with restrictions."

176. In its determination on misconduct and impairment, the Committee identified the extent to which the Registrant presents an ongoing risk to the public and to the public interest. The Committee therefore concluded, given the Registrant's absence of insight

and lack of demonstrable remediation, that it was not possible to formulate workable and practicable conditions that would adequately address the Registrant's dishonest misconduct. In any event, the Registrant has not provided any information that would suggest that he was willing or able to comply with any conditions, even if they could be formulated. The Committee therefore concluded that the risks identified could not be properly managed through conditions.

177. The Committee then went on to consider the imposition of a period of suspension. The Committee noted the guidance that suspension may be appropriate where:

"The committee considers that a warning or conditions are insufficient to deal with any risk to patient safety or to protect the public, or would undermine public confidence. It may be required when necessary to highlight to the profession and the public that the conduct of the Registrant is unacceptable and unbefitting a member of the pharmacy profession. Also when public confidence in the profession demands no lesser sanction."

178. Having regard to all the circumstances of this case, given the aggravating factors identified, the Committee concluded that the Registrant's misconduct too serious for such an outcome.

179. The Committee noted the guidance as to when Removal would be an appropriate sanction to impose:

"*Removing a registrant's registration is reserved for the most serious conduct. The committee cannot impose this sanction in cases which relate solely to the registrant's health. The committee should consider this sanction when the registrant's behaviour is fundamentally incompatible with being a registered professional.*"

180. Having considered all the circumstances surrounding the Registrant's misconduct, the Committee concluded that removal was the only appropriate and proportionate sanction to impose. The Committee was mindful that such a sanction should be reserved for the most serious cases. However, it concluded that, relating as it did to repeated dishonest behaviour over a three year period, an absence of insight and

remediation, this was one such case. The Registrant's misconduct, the Committee concluded, was fundamentally incompatible with continued registration.

181. It therefore concluded that only removal would meet all three limbs of the overarching objective. The Committee therefore directs removal of the Registrant's name from the Register.

DETERMINATION

Interim Measures

182. The decision to impose a sanction of removal will not take effect until 28 days after the Registrant is formally notified of the outcome, or until any appeal, if made, is concluded. The Committee sought submissions from Ms Khanna on whether interim measures should be imposed to cover this period.

183. Ms Khanna stated that she was instructed to apply for interim measures to be imposed pursuant to Article 60 of the Pharmacy Order 2010, pending the coming into force of the Committee's substantive order. The application was made on the grounds that, given the Committee's earlier findings, reflecting an ongoing risk of repetition of the Registrant's misconduct, it was necessary to protect the public and was otherwise in the public interest and would otherwise be inconsistent with the Committee's substantive findings.

184. The Committee noted that in its Notice of Hearing dated 8 December 2023, the Registrant was notified that "*Should the Committee direct the removal or suspension of your name from the Register or give a direction for conditional entry, it may also impose interim measures pending the direction taking effect at the end of the 28 day appeal period. This is set out in article 60 of the Pharmacy Order 2010.*" However, no submissions have been received by, or on behalf of the Registrant.

185. The Committee has carefully considered the submissions made and has considered them in the light of its earlier determinations.

186. In imposing its substantive sanction, the Committee has identified that only a sanction of removal from the register was sufficient to address the ongoing risk to the public and the public interest. That, the Committee concluded, was essential to protect both the public and the public interest for the reasons set out in its determination on sanction.

187. Should interim measures not be put in place, that objective would be undermined as the Registrant would be able to practise without restriction pending not only the appeal period, but for an extended period of time if the decision of this Committee is appealed. That, the Committee concluded would not meet the overarching objective as set out earlier in this determination.

188. The Committee was therefore satisfied that an interim measure of suspension is necessary for the protection of the public and is otherwise in the public interest in order to maintain public confidence in the pharmacy profession and the regulatory process. The Committee therefore imposed an interim measure of suspension pursuant to Article 60(2) of the Pharmacy Order 2010.

189. There is no interim order to revoke.

190. This concludes this determination.