General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Virtual Hearing

18-26 March 2024

Registrants' names:	Mohammed Amier (R1)
Registration numbers:	2076769 (R1)
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Sarah Hamilton (Chair) Steve Simbler (Registrant Member) Wendy Golding (Lay member)
Secretary:	Chelsea Smith
Clinical Advisor:	Dr Sabari Muthukrishnan
Registrants:	R1 - Present and represented by Paul Summerfield
General Pharmaceutical Council:	Represented by Ryan Ross
Facts proved:	15 (in relation to 14(b))
Facts proved by admission:	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 & 14
Facts not proved:	15 (in relation to 14(a))
Fitness to Practise:	Impaired
Outcome:	Suspension for 12 months

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 30 April 2024 or, if an appeal is lodged, once that appeal has been concluded. However, the interim suspension set out in the decision take/s effect immediately and will lapse when the decision takes effect or once any appeal is concluded.

This was a joint hearing involving two registrants, only the determination in relation to Mr Amier's case is publishable, in accordance with the *GPhC publication and disclosure policy.*

Documentation

Document 1 - Council's bundle (964 pages)

Document 2 - Council's statement of case and skeleton argument

Document 3 - R1's bundle (218 pages)

Document 4 - R2's bundle (195 pages

Document 5 - R2's statement of case

Document 6 - R2's witness statement

Document 7 - R1-s signed witness statement

Document 8 - Full Assessment Report for R1

Document 9 - Council's hearsay submission

Document 10 - R2' submissions on facts

Document 11 - Registrar's Rule 6 consideration of allegation against R2

Document 12 - GPhC internal email re R2 4 April 2023

Document 13 - GPhC internal email re R2 21 September 2022

Document 14 - R2's schedule of costs

Document 15 - R2's fee note

Witnesses

- Witness 1, Expert Good Distribution Practice Inspector at MHRA at the time of the allegations - gave evidence at facts stage
- Witness 2, Quality Head UK, Janssen-Calig - gave evidence at facts stage
- AP - Senior Clinical Pharmacist Ealing Hospital - witness statement admitted by all parties
- NC - Senior Clinical Pharmacist, Central Middlesex Hospital - witness statement admitted by all parties
- DC - Consultant in General Medicine and Gastroenterology - witness statement admitted by all parties
- R1 gave evidence at the facts and impairment stage
- R2 gave evidence at the facts stage

DETERMINATION ON FACTS

1. This is a Principal Hearing in respect of Mr Mohammed Amier ("R1"), a Pharmacist registered with the General Pharmaceutical Council ("the Council") under registration number 2076769, and [REDACTED] ("R2"), also a Pharmacist registered with the Council under registration number [REDACTED]. Both Registrants are present at this hearing. R1 is represented by Mr Summerfield. R2 is represented by Mr Livingstone. The Council is represented by Mr Ross.

THE ALLEGATION AGAINST R1

2. The Particulars of Allegation against R1 are as follows:

"You, Mohammed Amier, a registered pharmacist,

1. Around November 2019, you signed Ms A's signature on a Service Level Agreement ("SLA") between British Chemist and Ealing Hospital NHS Trust.

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

a. did not have permission to sign the SLA on behalf of Ms A; and

b. knew you did not have permission to sign the SLA on behalf of Ms A; and

c. did not make it clear you had signed the SLA on behalf of Ms A.

3. Between April 2019 and March 2021, whilst employed at Pharmacy Bond, you:

a. prepared false and / or template prescriptions; and / or

b. were aware orders were being submitted to pharmaceutical companies, including but not limited to those set out in Schedule A, using false and / or template prescriptions.

4. In relation to your actions as set at paragraph 3 above, you knew that:

a. false and / or template prescriptions were being submitted with orders for pharmaceutical products; and / or

b. the orders were not in respect of genuine patient demand.

5. Your actions as set out at paragraph 3 above were dishonest by reason of paragraph 4.

6. Between January 2020 and January 2021, whilst employed at Mojji LS Ltd, you:

a. prepared false and / or template prescriptions; and / or

b. were aware orders were being submitted to pharmaceutical companies, including but not limited to those set out in Schedule B, using the false and / or template prescriptions.

7. In relation to your actions as set at paragraph 6 above, you knew that:

a. false and / or template prescriptions were being submitted with orders for pharmaceutical products; and / or

b. the orders were not in respect of genuine patient demand.

8. Your actions as set out at paragraph 6 above were dishonest by reason of paragraph 7.

9. On or around 18 June 2020 you wrote to Oxford University Hospital NHS Trust ("OUH") and confirmed the medications ordered from OUH would be supplied to patients and not for any other purpose.

10. Your conduct at paragraph 9 above was dishonest in that you:

a. knew the information provided to OUH was not true; and / or

b. did not reasonably believe the medication would be provided to patient(s).

11. Between April 2019 and March 2021, while employed at Pharmacy Bond, you:

a. submitted orders on one or more occasions to pharmaceutical companies, including but not limited to Janssen-Cilag and Alcura, for pharmaceutical products using false and / or template prescriptions; and / or

b. signed declaration forms which confirmed the order was made in respect of genuine patient demand; and / or

c. signed Mr B's signature on declaration forms.

12. In relation to your actions as set out at paragraph 11 above, you knew that you:

a. were submitting false and / or template prescriptions; and / or

b. the orders were not in respect of genuine patient demand; and / or

c. did not have permission to sign the declaration forms on behalf of Mr B;

d. knew you did not have permission to sign the declaration forms on behalf of Mr B; and / or

e. did not make it clear you had signed the declaration forms on behalf of Mr B.

13. Your actions as set out at paragraph 11 above were dishonest by reason of paragraph 12.

14. On or around 4 March 2022, you stated in a response to the ongoing GPhC investigation that:

a. the MHRA had approved Noviscom/4Pharma to act on your behalf;

b. you had been in 'prolonged' negotiations with Northwick Park Hospital regarding a Service Level Agreement;

15. Your conduct at paragraph 14 above was dishonest in that you:

a. knew the information provided in response to the GPhC investigation was not true; and / or

b. did not reasonably believe the information provided in response to the GPhC investigation was true.

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

Schedule A

AAH

Abbvie

Alcura

Alliance Healthcare

Alloga

B&S

HAH

Healthcare at Home

Janssen-Cilag

Movianto

Novartis

OTC

Pharmahouse

Phoenix

Schedule B

AAH

Abbvie

Alliance Healthcare

BMS

HAH

Novartis

Oxford University Hospital NHS Trust

Shire Pharmaceuticals"

Introduction

3. This 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").

4. The statutory overarching objectives for 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.

5. The Committee also had regard to the guidance contained in the Council's *Good decision making: Fitness to practise hearings and sanction guidance* (as revised March 2017).

6. A Principal Hearing has up to three stages:

    - Stage 1. Findings of Fact – the Committee determines any disputed facts.
    - Stage 2. Findings of statutory ground(s) 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

7. The Committee has seen letters dated 5 February 2024 from the Council headed 'Notice of Hearing' addressed to both Registrants, notifying them of the date of this hearing. The Committee was satisfied that there had been good service of the Notice in accordance with Rules 3 and 16.

APPLICATION FOR THE HEARING TO BE HELD PARTLY IN PRIVATE

8. Mr Summerfield on behalf of R1 made an application under Rule 39(3) to hold those parts of the hearing dealing with R1's health and personal family matters in private. Mr Ross and Mr Livingstone agreed with the application.

9. The Committee decided to hold certain parts of the hearing in private as there will be reference to R1's health and personal family matters, in order to protect his right to privacy. All remaining parts of the hearing would be heard in public. Mr Summerfield had no objection to an employee of the Council remaining in the hearing room as an observer.

APPLICATION TO ADMIT HEARSAY EVIDENCE

10. Mr Ross made an application to admit an email from the Acting Head of Contracts at Northwick Park Hospital to the Council dated 16 August 2022 as hearsay evidence. This email stated that the hospital could find no evidence of a Service Level Agreement ("SLA") with R1, or any evidence that they had had discussions with him regarding a possible SLA. Mr Ross conceded that no witness statement had been obtained from this person at the hospital.

11. Rule 24 states that:

"(1) All questions of admissibility of evidence and law before the Committee are to be decided by the Committee (after having obtained the advice of the legal adviser, where appropriate).

(2) Subject only to the requirements of relevance and fairness, the Committee may receive—

(a)subject to paragraph (3), any documentary evidence; and

(b)where a hearing is held, any oral evidence,

whether or not such evidence would be admissible in any subsequent civil proceedings if the decision of the Committee were appealed to the relevant court."

12. Mr Summerfield and Mr Livingstone made no objection to this application.

13. The Committee agreed to admit this hearsay evidence. It had regard to Rule 24 and to the guidance in the case of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin),* which included consideration of whether the statement was the sole or decisive evidence in support of the charge; the nature and extent of the challenge to the contents of the statement and whether there was any suggestion that the witness had reasons to fabricate their allegation. In R1's case this was not the sole and decisive evidence as R1 had indicated that he intended to admit Particular 14(b) of the Allegation. He did not object to the Council adducing this evidence, and there was no suggestion that it had been fabricated. The evidence would be relevant to Particular 15 (dishonesty), which is denied. The Committee decided that the tests of fairness and relevance were both made out.

14. The Council's application to admit this hearsay evidence was therefore granted by the Committee.

R1'S RESPONSE TO THE PARTICULARS OF ALLEGATION

15. At the start of the hearing R1 admitted all of the Particulars of Allegation apart from Particular 15. For Particulars 3, 4, 6, 7, 11 and 12 he admitted that the prescriptions were templates, but not false. As those Particulars are drafted in the alternative (i.e.*template prescriptions and/or false prescriptions*) the Committee considered that

it could find these particulars proved by way of admission. However, the Committee would go on to decide in its determination on facts whether the prescriptions were also false.

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

17. Therefore, the only Particular which R1 denied was Particular 15.

THE ALLEGATION AGAINST R2 (AS AMENDED)

18. [REDACTED]

R2'S RESPONSE TO THE PARTICULARS OF ALLEGATION

19. [REDACTED]

BACKGROUND

20. The Allegations relate to events which occurred whilst R1 was the owner/Company Director and/or Responsible Person for two pharmacies: (i) Mojji LS Ltd, trading as British Chemist and Clinic; and (ii) Pharmacy Bond Limited. R2 was joint owner of Pharmacy Bond Limited. R2 was not a part owner of British Chemist. (Redacted).

21. In opening the case for the Council Mr Ross summarised the allegations against R1 and R2 as a *"systematic and long running enterprise to deceive pharmaceutical companies into supplying them with medicines for patients that did not exist."* He said this included specialised, high value medicines which R1 and R2 wholesaled for profit, against rules which were in force to ensure that the medicines market was not

distorted and that UK patients were not denied such medicines. He said that such wholesaling is not in the public interest and does not protect the public.

22. Concerns were first reported to the Council on 31 December 2019 by Witness 2, Quality Head UK of Janssen-Cilag, the pharmaceutical branch of Johnson and Johnson. Pharmacy Bond had an account with Janssen-Cilag and had, in the past, been supplied with medicines for various care homes. Janssen-Cilag never supplied products to British Chemist prior to December 2019.

23. In December 2019, Janssen-Cilag's customer services team flagged internally that it had a concern regarding R1's conduct. It was believed that he had fraudulently attempted to obtain high value products for British Chemist. The concerns centred on what was thought to be a falsified signature on a Service Level Agreement ("SLA") that had purportedly been made between British Chemist and Ealing Hospital NHS Trust. The signatory from Ealing Hospital NHS Trust was named as "AP".

24. The Council contacted AP, and she signed a witness statement. She is a Senior Clinical Pharmacist at Central Middlesex Hospital, which is part of London North West Healthcare NHS Trust. The Trust is made up of three hospitals - Central Middlesex Hospital, Northwick Park Hospital and Ealing Hospital. She was clear that she had never worked at Ealing Hospital, had never had any involvement with R1 nor with British Chemist, and had never even heard of R1 before the Council's investigation commenced. She stated that she did not sign the SLA. She had not entered into a SLA with R1 on behalf of the Hospital, and the signature on the SLA was not hers.

25. In April 2021, the Medicines & Healthcare products Regulatory Agency ("MHRA") began investigating R1 and his two pharmacies in respect of his Wholesale Dealers Licences ("WDL"). The MHRA's investigation overlapped with the Council's investigation.

26. Witness 1 was the Expert Good Distribution Practice Inspector within the Inspection, Enforcement and Standards Division at the MHRA until January 2023, when he left the organisation to become a self-employed pharmaceutical consultant. In his witness statement dated 9 November 2021 he explained that a WDL permits companies to sell or supply medicines to anyone authorised to receive them, such as other wholesalers or pharmacies, but not directly to a patient using the medicine. A pharmacy that wants to wholesale medicines commercially must have a WDL to do so. It is a condition of all WDL licences that the organisation needs to ensure continued supply of medicinal products to ensure the needs of patients in the UK are met. This is an obligation on the licence holder, as set out in Regulation 43(2) of the Human Medicines Regulations 2012. The Responsible Person is responsible for ensuring that all conditions of the licence are complied with.

27. The MHRA's concern was that R1 (the Responsible Person) was ordering high value products from pharmaceutical companies and then wholesaling those products in breach of the conditions of the WDL. Witness 1 reviewed records and stated that R1 was purchasing from manufacturers a range of high-value medications through Pharmacy Bond when he had no patients to supply them to. Instead, he then sold those medications onto the European market a few days later in what amounted to an act of wholesaling.

28. One supplier, Abbvie, informed Witness 1 that R1 had procured medications from them on the basis of the need to supply patients of Alexander's Care and Support Agency ("ACASA"). However, none of the Abbvie products were ever used by ACASA. Instead, they were all sold on.

29. Witness 1 discovered two order forms and two prescriptions from Alcura UK Ltd where Pharmacy Bond had ordered four quantities of Eviplera tablets. Alcura acts for

Gilead Sciences Ltd, who are the marketing authorisation holders of Eviplera. Gilead has a validation requirement that the Eviplera products are not purchased with the intention of exporting them. All orders must contain a prescription.

30. Witness 1 also stated that two orders were made in October 2020 by R2,(Redacted). The products were then sold on to Shakespeare Pharma a few days after receipt. R1 said that he provided the order forms but that they had R2's name on them. In his representations to the MHRA on 27 May 2021, R1 admitted giving the impression that the products he purchased would be used for his pharmacy, when in fact he wholesaled them. In his further representations to the MHRA on 15 July 2021, R1 denied that he had been falsifying prescriptions, but accepted that he had been using prescription templates to obtain the products. R1's defence was that he assumed, being a small pharmacy, that the only way he could obtain medicines for wholesale trade was through misrepresentation. He initially admitted being motivated by profit and using template materials to mislead. However, by 3 July 2021, R1 had changed his position on this issue, and submitted that the use of prescription templates was not the same as using false prescriptions, that it was not illegal and that it was common practice.

31. The MHRA opened and then closed an investigation into Mojji LS Limited's ordering of a high-value product (Stelara) in January to March 2020. Separately, on 11 December 2020, R1 was reported to the Council by a member of staff of Shire Pharmaceuticals Limited. It was alleged that R1 had opened an account with Shire to purchase two specialist rare injectable cool chain products called Elaprase. These products are hospital medications, and Shire grew suspicious after the reasons given by R1 for requiring the products did not appear to be plausible.

32. The MHRA reopened its investigation in April 2021. In representations to the MHRA on 9 June 2021, R1 admitted that he may have given the impression he was ordering

Stelara for patients when, in fact, he wholesaled them.

33. The MHRA considered that Mojji LS Limited was using its status as a registered pharmacy to obtain products when there were no patients, and then wholesale the products. Witness 1 gave an example of where this happened with Elaprase on 30 November 2020 to 2 December 2020. Witness 1 identified other instances of high-value products being ordered and then wholesaled, including purchases of Replagal and Elaprase which were bought and sold on to Optimal Pharma Ltd and Shakespeare Pharma Ltd in October/November 2020. Replagal was purchased from Takeda Ltd with prescriptions signed by 'Amier' but they were not supplied to patients. Instead, they were sold on, two to three days later. In his representations to the MHRA on 30 July 2021, R1 said that he had used template prescriptions to keep his account with Takeda open.

34. As part of the MHRA's investigation, an invoice was found from Oxford University Hospital NHS Trust ("OUH") to Mojji LS Limited dated 2 October 2020. The invoice was for five products (Stelara) totalling £54,781.82. In his representations to the MHRA on 30 July 2021, R1 confirmed that he had told OUH that the five products would be supplied to patients. However, the products were actually sold to Optimal for £106,981. In his letter to OUH dated 18 June 2020, R1 had stated that the '*medications will be supplied to our patients who come to our clinic and not for any other purpose'*.

35. The only Particular of Allegation which R1 denied was that he was dishonest when responding to the Council's investigation. He admitted that in March 2022, he told the Council that the MHRA had approved Noviscom/4Pharma to act on his behalf and that he had been in '*prolonged*' negotiations with Northwick Park Hospital regarding a Service Level Agreement but denied that this was dishonest. He told the Council that in September 2013 he had contact from Noviscom/4Pharma who were offering to assist him in obtaining a WDL and establishing a wholesale pharmacy business. He

said that he was aware that they were significant wholesalers working with many hundreds of pharmacies and were approved by the MHRA. He stated that "*the MHRA had approved Noviscom/4Pharma to act on my behalf*". Witness 1 said that Pharmacy Bond Ltd was never authorised with Novisocom/4Pharma as an approved third-party. In support of that point, Witness 1 referred to a representation from R1 made on 28 September 2016 that '*…we will not be letting Logan Pharmaceuticals or anyone else order any stock on our behalf…*'. As far as any SLA is concerned, the Acting Head of Contracts at Northwick Park Hospital, said that there is no evidence of any SLA with R1, nor any evidence that anyone in the pharmacy department had any discussions with R1 about an SLA.

36. R2 faced fewer allegations. He (Redacted), and together they owned Pharmacy Bond Limited. R1 has stated that he used R2's name on the orders without his knowledge. However, the Council's position is that there are "*significant issues*" with R1's credibility, and therefore it alleged that R2 was party to the wholesaling fraud undertaken by Pharmacy Bond and that he prepared, allowed or permitted falsified prescriptions to be sent out to obtain medical products, which were then wholesaled.

WITNESS EVIDENCE

37. The Committee heard oral evidence under oath from Witness 1, Witness 2, R1 and R2. It also read written statements from AP dated 20 May 2021, NC dated 9 October 2023 and DC dated 27 January 2024. As R1 had admitted all allegations relating to the evidence provided by these three witnesses, they were not required to give oral evidence.

Witness 1

38. Witness 1 gave oral evidence in line with his witness statement of 9 November 2021. Following the MHRA's initial investigation, which included contacting some of the suppliers, Witness 1 wrote to R1 in May 2021, setting out the alleged failures to

comply with the guidelines on good distribution practice of medicinal products for human use. The deficiency was noted as '*medicines that were intended for UK patients were supplied to companies by way of wholesale distribution and therefore the Licence Holder [had] failed to ensure, within limits of his responsibility, the continued supply of medicinal products so that the needs of the patients in the UK are met'*. The letter identified four orders relating to Eviplera and regular orders for Humira where it was clear that the products were being wholesaled.

39. On 18 June 2021, the MHRA issued a Notice of Proposed Variation and Notice of Suspension to Pharmacy Bond. On 15 July 2021, R1 provided written representations, along with a number of documents including a Corrective and Preventative Action report ("CAPA"), detailing how the company would identify the root cause of an issue and prevent its recurrence. R1 explained that whilst he was not falsifying prescriptions, he was using a prescription template to obtain the products. He appeared to accept there were no patients at the time who required the products being obtained.

40. On 16 August 2021, a Notice of Variation to remove R1 as the Responsible Person was issued to Pharmacy Bond, together with a Notice of Suspension for nine months. Witness 1 wrote to R1 to confirm that the MHRA would not vary the WDL to add R2 as the Responsible Person as had previously been requested. On 16 August 2021, R1 completed a request to terminate Pharmacy Bond's MHRA licence. Pharmacy Bond no longer holds a WDL.

41. On 24 August 2021, a Notice of Variation to remove the R1 as the Responsible Person was issued to Mojji LS Limited, together with a Notice of Suspension for a period of nine months. On 21 September 2021, the MHRA was advised in an email that R1 wanted to terminate the licence for Mojji LS Limited. There is reference in this email to R1 unknowingly following 4Pharma and Noviscoms' illegal practices.

42. Witness 1 confirmed that Mojji LS Limited no longer holds a WDL.

43. In his oral evidence, during cross examination by Mr Summerfield, Witness 1 confirmed that Pharmacy Bond never made an application to name Noviscom or 4Pharma on their WDL. He confirmed that there were other cases where parties were ordering in a similar manner to Pharmacy Bond, and in those cases the MHRA took the same action - they suspended the pharmacy's licence and reported them to the Council.

44. During cross examination by Mr Livingstone, Witness 1 confirmed that he always dealt with R1. The only time he came across R2 was when an application was made by Pharmacy Bond to name R2 as the Responsible Person, but even then, he did not have any dealings with R2, as the application was made by R1.

45. Mr Livingstone took Witness 1 to several of the prescriptions and order forms which were sent to the MHRA during its investigation. Although the order forms had R2's name and his signature on them, Witness 1 was not in a position to say whether the forms were actually signed and submitted by R2.

46. The Committee asked Witness 1 to provide some background as to why some suppliers made certain restrictions regarding wholesale transactions. Witness 1 explained that prior to the Brexit vote, at some stage the UK pound was strong against the Euro, which made it attractive to export high value medications from the UK to Europe. A number of pharmacies obtained a WDL so that they could legitimately do this. Some high value medicines were limited in terms of the volume available, so a few companies, such as Janssen-Cilag, introduced a requirement that the pharmacy ordering the stock must be able to show that the medicine was being

purchased against an actual prescription (i.e. to show that there was a patient in the UK who required the medicine). In this way shortages of medicines for the UK market would be managed, as this would prevent those medicines from leaving the UK and going overseas. This was a requirement that individual companies introduced, and Witness 1 said that in the absence of such a requirement, there was no regulatory requirement which prevented the pharmacy from selling the medicine to patients abroad.

47. Witness 1 also clarified that a wholesaler always needs to know who their customer is, and it is a requirement of the Good Distribution Practice ("GDP") for wholesalers to monitor suspicious transactions. He said that there is nothing wrong with a company purchasing stock from a wholesaler for both pharmacy and wholesale purposes, but the stock must be kept separate whilst in the pharmacy. The wholesale stock needs to be kept in a separate wholesale area.

Witness 2

48. Witness 2 gave oral evidence under oath in line with his witness statement dated 26 January 2022. At the time of these allegations, he was the Responsible Person named on the MHRA WDA licence awarded to Janssen-Cilag. He recently left Janssen-Cilag to work for another pharmaceutical company as the Responsible Person. He stated that at the time of the allegations Pharmacy Bond already had an account with Janssen-Cilag as historically it had a genuine patient demand for neuroscience medicines for care homes.

49. Witness 2 became suspicious when he started making enquiries about the SLA allegedly signed by AP as part of his routine due diligence. During correspondence between R1 and Witness 2, R1 provided a screenshot of an email chain between himself and London North West University Healthcare NHS Trust, and a screenshot of a Division of Medicines Contract signed by R1 and AP.

50. Witness 2 confirmed that Pharmacy Bond had bought 218 units of Stelara at a cost of £468,000 in 2019. On 25 February 2020 R1 submitted a further order for Stelara and provided a private prescription from DC. A representative from Janssen-Cilag contacted DC, who confirmed that R1 had said that he had patients abroad who needed the medication in the UK. DC said that R1 had supplied him with a doctor's letter, and he subsequently prepared the prescription.

51. During cross examination, Mr Summerfield asked Witness 2 whether there was anything inherently wrong with a pharmacy buying medicines from Janssen-Cilag and then selling them on to a wholesaler. Witness 2 said that it depended on the product. For Stelara, this was a "hospital only" product which should not be distributed to community pharmacies. He said that Janssen-Cilag had close controls on this medication, ensuring that it went through one of its key patient support programmes which involved, for example, sending the product to a patient's house and arranging for it to be administered by a nurse (all of which is paid for by Janssen-Cilag). He could not recall if Stelara was on the Export Barred List at the time.

52. In response to questions from the Committee, Witness 2 conceded that Janssen-Cilag should never have been supplying Stelara to Pharmacy Bond, and that their system was not watertight, as 218 units had been supplied previously. However, before Christmas 2019 they had stopped supplying Stelara and requested a list of "customers" to whom Pharmacy Bond was supplying the medicine. R1 provided details of some of the companies which Pharmacy Bond worked with. Janssen-Cilag contacted some of those companies but none of them had been supplied with Stelara, and only one, ACASA, had heard of Stelara.

53. Witness 2 could not remember whether there was ever a time when R1 sent in orders for medicines. He accepted that he took R2's name and signature on the order forms

at face value, so could not say whether the forms were actually sent by R2. He was satisfied that R2 was a director of Pharmacy Bond, so if an order came in with R2's name on it, that was sufficient.

DC

54. DC's written witness statement is dated 27 January 2024. He confirmed that when he raised queries regarding the requested prescription for Stelara, R1 told him that the patient's doctor in Iraq had confirmed that the patient had Crohn's disease. DC asked for a letter from the doctor confirming the dates and dosages of medication previously prescribed. R1 provided a letter purportedly from that doctor. When DC out that the letter did not contain the doctor's name or credentials, R1 said that they were in Arabic, and translated them. DC then prescribed the medication.

AP

55. AP's written witness statement is dated 20 May 2021. She stated that although she worked for London North West University Healthcare NHS Trust, she had never worked at Ealing Hospital. She had never had any involvement with R1 nor with British Chemist and had never even heard of R1 before the Council's investigation commenced. She stated that she did not sign the SLA. She had not entered into a SLA with R1 on behalf of the hospital, and the signature on the SLA was not hers.

NC

56. NC's written witness statement is dated 9 October 2023. She is a Council inspector. She attended an inspection at British Chemist on 22 May 2023. During the inspection visit she asked to see the Responsible Pharmacist record. R1 produced a paper based Responsible Pharmacist record book. The entries were all made in his name from 2 November 2020 until 31 March 2021. He confirmed verbally and by email that he had been the only Responsible Pharmacist and he had not employed any locum pharmacists.

Registrant 1 (R1)

57. R1 gave evidence under oath for approximately two hours. Prior to the Principal Hearing he had supplied a 35-page witness statement dated 1 March 2024. In his statement he explained that he studied pharmacy at the University of Kingston, graduating in 2010. [REDACTED] In August 2012 they set up Pharmacy Bond Limited [REDACTED] and made an application to the NHS for a new distance selling pharmacy contract. R1 said that this was hard work and there were lots of barriers. As they had a distance selling pharmacy, they were not allowed to open to the public in the sense that people could not come into the pharmacy off the street.

58. R1 said that the other difficulty was that the concept of a pharmacy "in an office" was still new to patients so it was quite a challenge until patients got used to this method. R1 would "cold call" GP surgeries and patients' houses to try and obtain new business. The business was making a loss, and they were all supporting it financially using money earned through their part time locum work.

59. In June 2013, R1 heard about the idea of setting up a wholesale business, and was introduced to Noviscom, which provides healthcare regulatory services. 4Pharma is the trading arm of Noviscom. They assisted him to start the process of obtaining a wholesale licence. The contract which R1 signed with Noviscom confirmed that 4Pharma would cover all of the regulatory costs provided that they traded with 4Pharma for a minimum period of 12 months and that they met minimum levels of trade volumes. The agreement also provided for 4Pharma to provide regulatory support to assist with MHRA's legal and regulatory requirements. R1 said that it was also agreed that 4Pharma would assist with opening up accounts with other wholesalers and would assist with ordering and invoicing.

60. R1 said that 4Pharma assisted with obtaining the WDL and taught him the wholesale business. He was told that the wholesalers/manufacturers were not legally allowed to

refuse pharmacies stock and he learnt to challenge them. 4Pharma would copy him in on all orders and he could see that they were using NHS and private prescription templates to obtain stock. He was told that if the manufacturers called, they should explain that the medicines were needed for patient use and that the *"big pharma"* companies were breaking competition law by refusing to supply this stock to Pharmacy Bond. R1 said that he had therefore been led to believe that it was legitimate to provide *"dummy"* prescriptions in order to obtain stock, because he had been told that the suppliers were not allowed to restrict stock in any event.

61. In September 2014, the third partner in Pharmacy Bond left, so the business was then just owned by R1 and R2. In February 2016, they asked the MHRA to cancel the wholesale dealer's licence that they had obtained with Noviscom's help, as the lines they were relying on became "*hospital only*" lines and Noviscom were no longer able to procure them for Pharmacy Bond. In June 2016, R1 decided to reapply for a wholesale dealer's licence to support his NHS business which was struggling following NHS funding cuts. By that stage 4Pharma was no longer trading, so R1 found a new company called Logan Pharmaceuticals which helped him obtain a new WDL in 2016. Pharmacy Bond would get a list of the medicines that the wholesalers wanted, and they would try to obtain as much as they could. Unlike 4Pharma, however, Logan Pharmaceuticals did not procure the stock on their behalf, so R1 did this himself, using the knowledge that he had obtained from 4Pharma about how they ordered medicines. That included using template prescriptions, which R1 had seen 4Pharma do on many occasions, and which 4Pharma had assured him was routine and accepted practice in the industry.

62. By 2019/2020, Pharmacy Bond was ordering stock for wholesale supply from a number of wholesale dealers, including those listed in Schedule A of the Allegation. R1 said that when they opened the accounts for the wholesale side of the business, for the most part these were opened stating that the supplies were required for the pharmacy. They did not say that we were intending to wholesale stock. R1 said that

this is what they had been told by 4Pharma to say, and he did not question it at the time. He knew that he would not be permitted to set up an account if they thought that he was intending to wholesale the stock, as he would then be competing with the companies in the wholesale market, However, R1 maintained that two of the companies, Pharmahouse and Phoenix, knew all along that he was intending to wholesale stock.

63. R1 did not recall that they were ever asked to provide template prescriptions for AAH, B&S, HAH, OTC, Pharmahouse or Phoenix. They sometimes had to provide template prescriptions for Abbvie (more often at the beginning of their relationship), Alliance (for higher value lines), Janssen-Cilag and Novartis (who requested prescription numbers rather than the actual prescriptions). They always had to provide template prescriptions to obtain wholesale line stock from Alcura, Alloga and Movianto.

64. R1 referred to a spreadsheet provided by Witness 2, showing how much Risperdal and Xeplion were supplied to Pharmacy Bond. R1 said that between 2016 and 2021 they only obtained 18 boxes of Risperdal, of which three were transferred to the pharmacy. They received 80 boxes of Xeplion into the wholesale side of the business and 10 of those were transferred to the pharmacy. He said that this showed that they were prioritising the pharmacy side of the business even when they were obtaining stock that was originally intended to be wholesaled.

65. At some point Janssen-Cilag started refusing to supply Xeplion and Risperdal to R1. He thought that this could be because his name was on the order requests, and he was also named as the Responsible Person on the WDL. He therefore started to use [REDACTED] on the orders (R2). The Council has provided copies of emails to Janssen-Cilag attaching orders. All of the emails are signed as from R2. R1 said that where the

emails were attaching orders for wholesale stock, he sent them. For orders that were for genuine patients at the pharmacy, he said that R2 sent them.

66. Janssen-Cilag had previously supplied Stelara to the pharmacy, but at some stage refused to sell any more. They stated that Stelara was a "*hospital only*" line and they wanted proof that the pharmacy needed this medication for supply to genuine patients. R1 said that he therefore provided them a signed SLA between Pharmacy Bond and ACASA. He said that this was a genuine SLA between the two companies, but that he signed it in the name of R2 and put R2's signature on the document. He knew that if he put it in his own name, Janssen-Cilag would immediately refuse the supply. R1 said that R2 was not aware that he had done this.

67. R1 is a pharmacist independent prescriber. In order to obtain medicines from Alcura for the wholesale side of the business, he would generate a "*dummy"* prescription in his name that could be sent to Alcura. R1 said that this did not include any details such as the patient's name, address or date of birth, but he put a pharmacy label over that section of the dummy prescription to make it appear that the original version did have the relevant patient details redacted. He said that they were not signed by him, and were therefore not legally valid prescriptions, but were sufficient to enable them to obtain the stock from Alcura. Since the prescriptions were written in R1's name, R1 said that he could not then submit these to Alcura on behalf of the pharmacy to procure the stock. He therefore sent emails to Alcura with the prescriptions in the name of [REDACTED] R2. R1 said that at that stage, he honestly believed that he was not sending genuine prescriptions but merely templates to look like prescriptions, which he had understood was common practice within the industry, based on what he had been taught by 4Pharma.

68. In 2019 R1 decided to open another pharmacy called British Chemist (the trading name of Mojji LS Ltd.) R1 is the sole director of the company. The new pharmacy was

nearer to his home, so it would reduce the long commute that he had been doing to Pharmacy Bond. He was having issues with R2 in terms of running Pharmacy Bond. He said that they were not suited to working with each other. R1 set up British Chemist as an online pharmacy and his intention was to obtain an NHS distance selling pharmacy contract. R1 said that it was always his main intention to operate British Chemist as a pharmacy, but he knew that he would need an additional source of income to supplement the NHS income. By this stage the Brexit vote had happened and most wholesalers were talking about Brexit being the end of parallel trade. However, in the short term, he decided to get involved with the wholesale supply of medicines to supplement his NHS income. R1's NHS contract has not yet been approved, due to these fitness to practise proceedings.

69. R1 was granted a WDL for British Chemist. The wholesale side of the business operated in thesame way as it had for Pharmacy Bond. Each month R1 would receive purchase order requests from a number of wholesalers and would try to secure the products from the wholesalers that he had accounts with.

70. In early December 2019, R1 tried to open an account with Janssen-Cilag. They said that he would need to send them a prescription to show that he needed their medication for a patient. R1 thinks that he tried to send them a prescription template, but they would not accept it. He therefore had to think about how he could open an account with them. Pharmacy Bond had had a contract with Frimley Park Hospital to provide dossette box dispensing services to their patients. That arrangement had come to an end in June 2019 and R1 had spent a lot of time trying to find another hospital that he could provide this service to. As Northwick Park Hospital was local to his home, R1 said that he had had several discussions with them. In October 2019, he received an email from them "*out of the blue* '' asking if he would still be able to provide this service. In the meantime, in order to open an account with Janssen-Cilag, R1 thought that he could send them an SLA which would appear to show that he had an agreement with Northwick Park Hospital. The Trust has a private

section called St Marks Hospital which specialises in diseases such as Crohn's disease, which R1 thought would justify the requests that he was making to Janssen-Cilag at that time. R1 decided to prepare an SLA that purported to be between British Chemist and Northwick Park Hospital. He realised that it needed to be "signed" on behalf of the hospital, and he thought that he remembered the name of "*AP*'' being mentioned to him. He found someone of that name registered with the Council who lived in North West London, so he put her name on the SLA and "signed" it as though it had been signed by her. R1 subsequently sent to Janseen-Cilag a letter which purported to have been signed by London North West University Healthcare NHS Trust and an email, both of which were created by him in an attempt to open his account.

71. In February 2020, R1 attempted to place an order with Janssen-Cilag for Stelara. He was ordering it for wholesale purposes. He knew that he needed a prescription from the UK. He found DC on LinkedIn, who specialised in Crohn's disease. R1 invented a story that there was a patient in the Middle East who needed the medication, and already had an overseas prescription which was signed by his doctor but needed it transcribing by a UK-registered doctor so that R1 could supply the medication to the patient. R1 provided to DC a document which purported to be from the patient's treating doctor, which R1 had, in fact, written himself. Janssen-Cilag became suspicious and did not agree to make the supply.

72. In June 2020, R1 opened an account with Takeda to obtain stock for the wholesale side of the business and completed an account opening form. He obtained two medicinal products from Takeda, namely Elaprase and Replagal. He was not required to send prescriptions to Takeda in order to obtain stock, although he believes that he told them that the medicine was being supplied to UK patients who were working overseas. However, in December 2020, Takeda asked him to retrospectively provide some sample prescriptions for these patients. He did not tell them that he was wholesaling. He decided to retrospectively write out prescription templates in relation

to the medicines that he had obtained and sent them to Takeda. He also made-up documents which purported to be instructions from the patient's prescriber in the Middle East to the UK prescriber. Takeda subsequently closed his account.

73. In a further attempt to obtain medicines from wholesalers, R1 contacted Oxford University Hospitals ("OUH"), who agreed to supply medicines but asked that he provide written confirmation that the medicines were for patient use. He sent to them a letter on British Chemist's headed notepaper stating that the medicine was for supply to "*our patients who come to our clinic and not for any other purpose*". R1 said that this was not true, because the stock was, in fact, for wholesale supply. He eventually only placed three orders with OUH, and on all three occasions he sold the stock to Optimal Pharma.

74. R1 said that during the Council's investigation he provided truthful information regarding the MHRA's approval of Noviscom/4Pharma. He clarified with a trainee solicitor that the MHRA granted approval to Noviscom/4Pharma in 2013. He said that unfortunately, when she subsequently inquired with the MHRA, the focus was on the more recent wholesale licence application in 2016. R1 said that the MHRA then informed the trainee solicitor that they had not approved Noviscom, which is accurate since Noviscom had ceased trading by 2016. R1 relied on the technical agreement document between Pharmacy Bond Ltd and Noviscom from 2013, which the MHRA reviewed and still went on to issue a wholesale licence at that time.

75. R1 said that he acknowledges his lack of honesty and took full responsibility for this. He said that he has had time to reflect and can now see the mistakes he made, but at the time he was too close to matters to view them objectively. He said that he did not set out to deliberately act inappropriately or dishonestly. He understood that his actions could have brought the reputation of the profession into disrepute, and possibly contribute to the shortage of medication to patients in the UK.

76. During his oral evidence R1 maintained that Noviscom had been approved by the MHRA in 2013. He said that an inspector came to the pharmacy and saw Noviscom's name on the pharmacy documents such as the Standard Operating Procedures ("SOPs"). The inspector was new, so he called the MHRA and was told that this was permitted, and R1 therefore believed that Noviscom had been approved to act as a third-party on behalf of Pharmacy Bond. R1 was taken to his email to the Council on 4 March 2022 where he responded to the allegations. This email stated:

"*Around September 2013 I had contact from Noviscom/4Pharma who were offering to assist in obtaining a WDL/WDA(H) and establish a wholesale pharmacy business. I was aware that they were significant wholesalers working with many hundreds of pharmacies and were approved by the MHRA. I regarded this as an opportunity as I was newly married and travelling extensively working as a locum. [PRIVATE]. In September 2016 Pharmacy Bond was once again granted a WDL/WDA(H). As I was completely new to wholesale and as the MHRA had approved Noviscom/4Pharma to act on my behalf I therefore relied upon representations and instructions I received from them."*

77. R1 said that his reference in this email to MHRA approval related to the 2013 approval.

78. During cross examination R1 also maintained his position that he had been in "prolonged negotiations" with Northwick Park Hospital. Mr Ross took him to six emails between R1 and the Hospital between October 2019 and March 2020 regarding the possibility of R1 providing a dosette box service, which culminated in the hospital saying that they were not interested. When asked what he considered "prolonged" meant, R1 said that his understanding of the word was "*a very long time".* In his mind late 2019 to March 2020 was a prolonged period.

79. R1 was asked about his working relationship with R2. He said that they were partners in the business, shared the business premises and used the same email address. R2 took delivery of the wholesale stock when R1 was not there. In 2019 R1 had set up his own new business in Kingsbury, so R2 took over a lot of the tasks previously carried out by R1. R1 would still usually label up the wholesale stock ready for the courier to collect, but occasionally if he was not around R2 would do this. However, R1 was insistent that R2 knew nothing about the wholesale side of the business. He said that R2's time was taken up by the dosette boxes and the travel clinic. R1 said that R2 does everything "*by the book",* and "*would not let anything slide."*

80. [PRIVATE]

81. [PRIVATE]

Registrant 2 (R2)

82. R2 provided a 24-page witness statement prior to the hearing dated 5 March 2024. He gave oral evidence under oath for approximately one hour.

83. In his witness statement R2 provided a detailed explanation regarding his working relationship with R1 over the years. He said that his involvement in wholesaling was limited to receiving stock in and settling any invoices raised by all suppliers (including wholesale suppliers). He said that he was never involved in the ordering of wholesale stock. He argued constantly with R1 regarding Pharmacy Bond but said that the only arguments they ever had over wholesale were in relation to invoicing. He said that he did not know what was being ordered, so when he had to settle invoices, he was effectively "blindly" paying for medications that may not have been delivered. He said that R1 was disorganised and R2 got frustrated *"keeping track of things on top of the million other responsibilities I had especially since he was doing a lot of remote work*".

84. R2 said that the only stock he ever ordered which could potentially be confused with the wholesale stock referred to in the allegations were Risperdal Consta and Xeplion, which were only ever ordered for the purpose of fulfilling scripts for patients in local care homes, which Pharmacy Bond serviced. He said that the wholesale stock was segregated from normal pharmacy stock, and it was put in an area of the dispensary that was not physically visible to someone picking stock from the dispensary. He provided a hand drawn diagram of the dispensary to demonstrate this.

85. In addition, R2 said that the refrigerated wholesale lines were stored in a fridge dedicated to wholesale lines only and in a separate room to the pharmacy stock.

86. R2 denied that he had any knowledge about the wholesale ordering in his name prior to the Council's investigation. He said that it was only when the first bundle was provided by the Council that he became aware of the orders that had been placed in his name by R1. He said that R1 knows that R2 is not the type of person who takes any risks, both professionally or personally. He said that when they were applying for a mortgage for new business premises, the representative from the bank "*remarked that [R1] possessed the entrepreneurial spirit that could lead to significant financial success, albeit with substantial risk. In contrast, he perceived me as the cautious counterpart, less likely to achieve millionaire status but also less prone to financial loss. The banker emphasised the complementary nature of our partnership. It was a valuable insight that resonates to this day."*

87. R2 said that he has never had any direct correspondence or communication with Witness 1 from the MHRA. He said that he became "*partly aware"* when the WDL was suspended. He recalled R1 mentioning the possibility of R2 taking over as the Responsible Person, but R1 did not explain why. R2 also said that he never had any contact with Witness 2 of Janssen-Cilag. He said that all of the prescriptions that were

submitted by him to that company were for genuine NHS patients. He did send a complaint by email regarding a prescription and said that this is evidence that he did not know what R1 was doing: *"No sane person, who is doing something wrong, would then go on to complain and draw attention to themselves."*

88. R2 said that there are various documents in the Council's bundle which contain his signature, but he did not sign. Some relate to orders placed with Janssen-Cilag. One document is the SLA between Pharmacy Bond and ACASA Limited, which rented out space from Pharmacy Bond at their office in Farnborough. The respective companies agreed that Pharmacy Bond would supply pharmacy services to ACASA. R2 said that he did not sign this document, and that this is not his signature. R2 provided a copy of his passport which contained his actual signature.

89. During his oral evidence R2 said that the pharmacy and wholesale stock would often be delivered together, and there was no distinction between them. He said that he sometimes signed for the wholesale orders, but generally they were managed by other pharmacy staff. However, the wholesale stock was stored separately once inside the pharmacy. He reiterated that he never ordered the wholesale stock. By 2018, R2 was the pharmacy manager, dealing with all operational aspects of the pharmacy such as invoicing, paying bills, bookkeeping, VAT returns and banking. R1 was only working two and a half days a week at the pharmacy, as he was concentrating on his new business. R2 said that he was not happy about this but had no choice - "*he was going to do it whether I liked it or not".*

90. R2 accepted during cross examination that he received the wholesale stock and settled the invoices but maintained that the wholesale side of the business was a "*separate entity".* He said that R1 had no history of dishonesty and R2 had no reason to be alert that he was doing anything wrong. When it was put to him by Mr Ross that he must have known what R1 was up to as they both had access to the same email

address, R2 said that on Outlook he could not access sent emails (although accepted that he could on Gmail).

91. During re-examination R2 said that if he had known that R1 was sending redacted prescriptions he would have told him to stop, as this amounted to deception.

CLINICAL ADVICE

92. [PRIVATE]

93. [PRIVATE]

94. [PRIVATE]

COUNCIL'S SUBMISSIONS ON FACTS

95. With regards to R1, Mr Ross reminded the Committee that only Particular 15 of the Allegation remains to be decided. He said that R1 has produced no evidence to show that Noviscom was ever approved by the MHRA, even in 2013, and that Noviscom acting as an agent is very different to the MHRA approving them. He said that, in any event, the email sent to the Council by R1 on 4 March 2022 made it clear that he was talking about events in 2016.

96. Mr Ross invited the Committee to disregard the emails which R1 has produced from November 2022 to attempt to prove his "prolonged negotiations" with Northwick Park Hospital. Mr Ross reminded the Committee that the allegation related to what R1 told the Council in March 2022. He submitted that R1 was trying to provide legitimacy, by way of mitigation, for using AP's name on the SLA.

97. Mr Ross submitted that R1 knew he was being untruthful when he made both comments to the Council in March 2022, and that ordinary, decent members of the public would consider that to be dishonest.

98. [REDACTED]

R1'S SUBMISSIONS ON FACTS

99. Mr Summerfield asked the Committee to give natural meaning to the words "*prolonged"* and *"negotiations".* As far as Noviscom is concerned, Mr Summerfield submitted that following the inspection in 2013, R1 interpreted the inspector's assertion that it was fine to have Noviscom's name on the SOP documentation as the MHRA approving Noviscom. Mr Summerfied also asked the Committee to bear in mind R1's personality traits, as set out in the medical report he has produced.

Original paragraphs 100-139 have been removed as they weren't regarding R1s case.

DECISION ON FACTS

100. In reaching its decisions on facts, the Committee considered the documentation listed at the start of this determination, the oral evidence of the witnesses and the oral submissions made by Mr Ross for the Council, the oral submissions of Mr Summerfield for R1 [REDACTED]

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

102. The Committee has dealt with each Particular of Allegation against R1 which was denied or only partially admitted separately below.

ALLEGATION AGAINST R1

Particulars 3, 4, 6, 7, 11, & 12

3. Between April 2019 and March 2021, whilst employed at Pharmacy Bond, you:

a. prepared false and / or template prescriptions; and / or

b. were aware orders were being submitted to pharmaceutical companies, including but not limited to those set out in Schedule A, using false and / or template prescriptions.

4. In relation to your actions as set at paragraph 3 above, you knew that:

a. false and / or template prescriptions were being submitted with orders for pharmaceutical products; and / or

b. the orders were not in respect of genuine patient demand.

6. Between January 2020 and January 2021, whilst employed at Mojji LS Ltd, you:

a. prepared false and / or template prescriptions; and / or

b. were aware orders were being submitted to pharmaceutical companies, including but not limited to those set out in Schedule B, using the false and / or template prescriptions.

7. In relation to your actions as set at paragraph 6 above, you knew that:

a. false and / or template prescriptions were being submitted with orders for pharmaceutical products; and / or

b. the orders were not in respect of genuine patient demand.

11. Between April 2019 and March 2021, while employed at Pharmacy Bond, you:

a. submitted orders on one or more occasions to pharmaceutical companies, including but not limited to Janssen-Cilag and Alcura, for pharmaceutical products using false and / or template prescriptions; and / or

12. In relation to your actions as set out at paragraph 11 above, you knew that you:

a. were submitting false and / or template prescriptions;

103. R1 has admitted that for both Pharmacy Bond Limited and Mojji LS Limited, he prepared template prescriptions and was aware that orders were being submitted to pharmaceutical companies using these template prescriptions. He has also admitted that he knew that template prescriptions were being submitted with orders for pharmaceutical products, and that the orders were not in respect of genuine patient demand. However, he denied that the prescriptions which he submitted were *"false".*

104. In his skeleton argument Mr Ross submitted that R1 prepared false prescriptions with a view to obtaining medications that he otherwise would not have had easy access to, that his motivation was financial and that there was no genuine patient demand for these medicines. The Council stated that the pharmaceutical manufacturers whom R1 was corresponding with wanted evidence of genuine patient demand, and that is not evidenced by false prescriptions.

105. The Committee has set out above in the witness evidence section R1's explanations. He said that it was acceptable practice in the industry to submit "template" prescriptions, and he had been told by 4Pharma that it was not unlawful, as there was no signature on the prescription. R1 was purchasing from manufacturers a range of high-value medications through Pharmacy Bond when he had no patients. He then

sold those medications onto the European market a few days later in what amounted to an act of wholesaling.

106. The Committee noted that R1 explained that he would put a label over the area on the prescription where the name and address of the patient usually was, in order for this to appear that this was a genuine prescription. R1 also knew that the orders were not for genuine patient demand, but rather for wholesaling purposes, and he deliberately lied in his correspondence with, for example, Janssen-Cilag, when he confirmed that the medicines were for patient use. In his representations to the MHRA on 27 May 2021, R1 admitted giving the impression that the products he purchased would be used for his pharmacy when, in fact, he wholesaled them. R1 therefore knew that what he was doing was not permitted and that he was being untruthful. He knew that he would not be provided with the medicines unless he could show that they were for a genuine patient need. He therefore submitted prescriptions which he knew were false in order to deceive the pharmaceutical companies.

107. The Committee noted that the dictionary definition of "*false*" is *"made to imitate something in order to deceive*". That is exactly what R1 was doing - he was pretending that he had genuine patients and that the medications were to be supplied to those patients. He was trying to pass the prescriptions off as real prescriptions for real patients. [REDACTED] R2, said in evidence that this amounted to deception.

108. The Committee therefore finds that Particulars 3, 4, 6, 7, 11 and 12 are proved in their entirety, i.e. for both *"template*" and "*false*" prescriptions.

Particular 15

15. Your conduct at paragraph 14 above was dishonest in that you:

a. knew the information provided in response to the GPhC investigation was not true; and / or

b. did not reasonably believe the information provided in response to the GPhC investigation was true.

109. When considering whether a registrant has been dishonest, this Committee must consider the test as set out in the Supreme Court case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67* where Lord Hughes stated that:

"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."

Dishonesty regarding Particular 14(a)

110. R1 admitted that on 4 March 2022, he had stated in a response to the ongoing Council investigation that the MHRA had approved Noviscom/4Pharma to act on his behalf. He denied that this was dishonest.

111. In an email to the Council dated 22 July 2022, Witness 1 commented that Pharmacy Bond Ltd was never authorised with Novisocom/4Pharma as an approved third-party.

In support of that point, he cited a representation from R1 made on 28 September 2016 that *'…we will not be letting Logan Pharmaceuticals or anyone else order any stock on our behalf…'*

112. R1's position is that Noviscom had been approved by the MHRA to act on his behalf back in 2013, and that when the trainee solicitor inquired with the MHRA in 2022, *"the focus was on the more recent wholesale licence application in 2016".* During his oral evidence R1 told the Committee that when he applied for the WDL in 2013 an inspector from the MHRA came to the pharmacy. R1 showed him the SOPs which had Noviscom's name on them. Initially the inspector, who was newly qualified, queried this, and then said that he would have to make a telephone call to his employer to check. R1 said that after the inspector had made the call, he told R1 that this was fine, and so R1 believed that Noviscom was approved to act as Pharmacy Bond's agent. The Committee accepted R1's evidence on this issue.

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113. The Committee therefore finds that R1 genuinely believed that the MHRA had approved Noviscom as his agent, and there is no evidence to show that the MHRA subsequently told R1 that Noviscom was not approved as his agent. It therefore makes no difference whether R1 was referring to the situation in 2013 or 2016 in his response to the Council of 4 March 2022, as he believed that Noviscom had been approved as Pharmacy Bond's agent. The Committee also considered that in view of what the inspector told R1 in 2013, this was a reasonable belief. The Committee finds that by the standards of ordinary decent people, the Registrant was not being dishonest in this respect.

114. Particulars 15 (a) and (b) are therefore not proved in relation to Particular 14 (a).

Dishonesty regarding Particular 14(b)

115. In his representations to the Council on 4 March 2022, R1 also stated that he had been in *'prolonged and, at times, frustrating negotiations with Northwick Park Hospital*' over the SLA. London North West University Healthcare NHS Trust sent an email to the Council on 16 August 2022, stating that there is no evidence of any SLA with R1, nor any evidence that anyone in the pharmacy department had any discussions with R1.

116. R1 relied upon the documentation within the Council's bundle as evidence of the *"prolonged negotiations*." This consisted of approximately six emails between the hospital and R1 between October 2019 and March 2020 regarding R1's proposal for supplying a dosette box service, which culminated in an email from the Trust in March 2020 stating that "*this is not the route we will be going down at present*". This is the only documentation which R1 is relying upon. He also said that he had been in talks with the Hospital in November 2022, but that post-dated his email to the Council in March 2022.

117. The Committee noted that the first email from the Trust during this period was dated 28 October 2019, which came "*out of the blue".* It was from "Lee", a Senior Medicines Management Pharmacy Technician, and stated:

"*Late last year you had a conversation with one of our senior pharmacists at Northwick Park Hospital regarding the service you provide in outscurcing* [sic] *dosette boxes.*

I have been forwarded your details with the hope of gaining some further information regarding the service.

Do you still provide this service?"

118. It appears that R1 then had a telephone conversation with the hospital to discuss this. On 8 January 2020 he emailed the Trust stating:

"*I spoke to your colleague who informed me that you are trying something in house before outsourcing and that you will have an answer for this month about whether you would like us to start doing medications for you."*

119. The Trust replied, saying:

"*Please accept my apologies, I have a lot of different projects I am working on at the moment so I cannot put my full attention into this one. I have forwarded on your details and previous emails to a colleague of mine who will be in touch with you soon hopefully with some positive news".*

120. On 11 March 2020 R1 sent another email to the Trust, following up on a telephone call earlier that day. In this email he basically sets out again the service which he was offering in relation to dosette boxes. The following day, 12 March 2020, the Trust sent a reply stating:

"*Unfortunately, this is not the route we will be going down at present".*

121. This is the extent of emails between R1 and the Trust, where he was trying to persuade them to trial his services. In the Committee's judgement, this does not amount to "*prolonged negotiations*" regarding an SLA. Nowhere within these emails is there any suggestion that the Trust had agreed to even a trial of this service, and there is certainly no mention of any SLA, which is a document which would be negotiated after the customer had agreed, in outline, to use R1's services. R1 knew, when he emailed the Council in March 2022, that he was being untruthful, to try and justify his fraudulent use of AP's name on an SLA which he signed in November 2019. He knew this was untrue, and he had no reasonable belief that this was true. Even if he thought that a period of five months amounted to a "*prolonged*" period, there

were never any negotiations regarding an SLA. By the standards of ordinary, decent people, R2's conduct was dishonest.

122. The Committee therefore finds Particular 15 proved in respect of Particular 14 (b).

Original paragraphs 123-145 have been removed as they weren't regarding R1s case.

DETERMINATION ON IMPAIRMENT

123. Having found the majority of the Particulars of Allegation proved against R1, the Committee went on to consider whether they amounted to misconduct and, if so, whether R1's fitness to practise is currently impaired by reason of that misconduct.

124. In reaching its decision the Committee considered all the evidence and information before it at this stage and the previous stage of the proceedings, together with the oral submissions of Mr Ross and Mr Summerfield. R1 gave further evidence under oath at this stage.

R1'S EVIDENCE

125. R1 said that he admits he has made a lot of mistakes, but only ever as a wholesaler, and not in his practice as a pharmacist. In the 12 years he has been in practice he has not had one patient complaint. When asked how other members of the profession and the public would view his conduct, he said "*They would be surprised. I don't know. Everyone's different. They wouldn't like it".*

126. When asked by Mr Summerfield how the Committee could be assured that this conduct would not happen again, R1 initially said that he had given up his wholesale licence and had no intention of wholesaling pharmaceutical products in the future, but later on in his evidence said that there was a possibility that he would, but that they would only be generic medicines which were not high value.

127. R1 said that he felt bad for putting(Redacted), R2, through this process, and he was also sorry for involving Dr Chan and Ms Patel. He was pleased that ultimately, they did not have to come and give evidence before this Committee.

128. R1 had produced a one and a half page document entitled "Planned CPD", where he stated that he had read other GPhC fitness to practise decisions to allow him to gain a broader perspective on professional misconduct and ethical breaches.

129. R1 said that he had probably profited by around £200,000 by his conduct, enough to allow him to buy his second pharmacy.

130. In answer to questions from the Committee, R1 said that he saw being a wholesaler and a pharmacist as a conflict of interests, as a wholesaler is there to make money, whereas a pharmacist is there to protect the public. Although R1 said at the start of his evidence that he accepted the Committee's decision in full, when asked what he thought about "*template*" and "*false"* prescriptions, and whether there was any difference, he was unable to provide a cogent answer. He said that he knew his actions regarding the prescriptions were misleading, but did not think, at the time, that it was illegal. He is sure that he would never do this again, as he does not want to go through this fitness to practise process again. He said that it has been the worst thing that has ever happened to him.

131. When asked about his plans for the future, R1 said that he is ambitious and would like to open more branches of his pharmacy, as there is a great demand for this.

132. Towards the end of his evidence, in answer to the Committee's questions. R1 said that he is a Pharmacist Independent Prescriber but is not prescribing at the moment as the Council has placed an interim order on him which does not permit him to prescribe. When the Committee had retired to consider the issue of impairment, the lay member realised that she had sat on this interim order application in November 2023. The issue had not been picked up by the Council as it had a separate case number. The Committee asked the parties to reconvene so that this could be put on record. Mr Summerfield indicated that he was already aware of this, and he had no objection to the Committee continuing to consider this case. He said that the Committee is a professional committee, and he is satisfied that the lay member will put from her mind anything she learnt from the interim order hearing. For the avoidance of doubt, the Committee confirmed that the fact that R1 had an interim order imposed on him in relation to another case would form no part of its decision making in this case.

CASE LAW

133. The Committee's task is to consider the question of impairment in two separate stages. Firstly, it must consider whether R1's actions which have been found proved constitute the statutory ground of misconduct for the purposes of the fitness to practise criteria. If it finds misconduct, the Committee must then go on to consider whether his fitness to practise is currently impaired.

134. The case law is clear that not every failing amounts to misconduct: it has to be serious, the type of behaviour that other members of the profession would regard as well below the expected standards, or "deplorable". In the case of Roylance *v GMC (No.2) [2000] 1 AC 311* by Mr Walker, Lord Clyde said that 'misconduct' was:

"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…And such falling short must be serious."

135. Further, in the case of *Remedy UK Ltd v General Medical Council [2010] EWHC 1245 (Admin)* it was said that:

> *"Misconduct is of two principal kinds. It may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur outside the course of professional practice, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession."*

136. In this case it is the first type of misconduct that is alleged, as it involved R1's exercise of professional practice.

COUNCIL'S SUBMISSIONS ON MISCONDUCT

137. Mr Ross submitted that R1's conduct fell far below the standards expected of him as a registered pharmacist and amounted to misconduct. In determining misconduct, it is submitted that the Committee should consider the Council's Standards for pharmacy professionals dated May 2017 ("the Standards"). It is submitted that R1 breached the following standard:

- **Standard 6** (acting with honesty and integrity)

138. The Council submitted that the conduct set out in the Particulars of Allegation was repeated and occurred over a period of over 18 months. The conduct in respect of R1 involved an initial denial and/or dishonesty towards his regulator (Allegations 14 and 15). The conduct was deliberate and not borne out of ignorance or naivety.

R1'S SUBMISSIONS ON MISCONDUCT

139. Mr Summerfield said that R1 accepted that the Committee was likely to find that proven facts amount to misconduct.

DECISION ON MISCONDUCT

140. The Committee bore in mind that the Standards may be taken into account when considering the issues of statutory ground and impairment, but that a breach of the Standards does not automatically result in a finding of misconduct (Rule 24(11)).

141. The Particulars of Allegation which have been found proved against R1 relate to his attempts to circumnavigate his responsibilities under his WDL whilst owning two separate pharmacies. He was repeatedly creating false prescriptions in order to obtain medicines for wholesale. He told the pharmaceutical companies that there were genuine patients when this was untrue. He went to the trouble of forging various documents, including an SLA with an NHS Trust and falsifying another pharmacist's signature on it, and forging emails from the Trust. He made up a story about a patient in the Middle East, and fabricated a letter from a doctor in Arabic, to try and persuade DC that he had a client who needed medication.

142. These were serious incidents of repeated dishonesty. His conduct was premeditated and took great efforts, such as forging documents and adding signatures which were not his own. This is not a case where there was a "moment of madness" - the dishonesty was repeated and sophisticated. His dishonesty impacted on AP, DC and (Redacted), R2. The incidents occurred over a lengthy period of time, and if R1's efforts to obtain medication fraudulently from one supplier failed, he would then try with another.

143. In terms of the Standards, the Committee agreed with the Council that R1 breached Standard 6. When he was questioned by Janssen-Cilag, the MHRA and the Council he was not open and honest and did not admit his misdemeanours. Instead, he continued to tell untruths, for example telling the Council that he had been in lengthy negotiations with Northwick Park Hospital regarding an SLA, presumably to try and justify his dishonest behaviour regarding the forged SLA with Ms Patel's name and signature.

144. In light of this, the Committee has no hesitation in finding that R1's conduct would be viewed as deplorable by both other members of the profession and members of the public, and therefore amounts to misconduct.

COUNCIL'S SUBMISSION ON IMPAIRMENT

145. Mr Ross referred to Rule 5(2), which states that:

"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 or behaviour—

(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."

146. Mr Ross submitted that all four limbs are engaged in this case.

R1'S SUBMISSIONS ON IMPAIRMENT

147. Mr Summerfield submitted that although his client did not believe at the relevant times that he was doing anything untoward regarding the prescriptions, he is now fully aware that the way he acted was dishonest by the standards of ordinary individuals. He has reflected extensively on his conduct and can see how this fell short of what would be expected of a pharmacist.

148. It is submitted that R1 has expressed remorse and regret in the way he acted, including involving other parties in his conduct. He understood that his actions have brought the profession into disrepute. Mr Summerfield submitted that there was no evidence of risk to patients.

149. In terms of remediation, Mr Summerfield said that although dishonesty is sometimes difficult to remediate, it is not impossible. He drew the Committee's attention to R1's document entitled "Planned CPD". He said that this, together with R1's written reflection and oral evidence, amounts to almost complete remediation. He said that the risk of repetition was very low.

150. In terms of R1's insight, Mr Summerfield submitted that this is deep and meaningful. He admits that his fitness to practise is impaired by his past misconduct, and that a finding of impairment is likely to be made on the grounds of public interest. He submitted that R1's dishonesty was towards the "lower end" of the scale as discussed in the Professional Standards Authority's paper *"Dishonest behaviour by health and care professionals."* He submitted that the risk of repetition is minimal.

151. Mr Summerfield also referred to the case of *Wingate & Evans v Solicitors Regulation Authority v Malins [2018] 1 WLR 3969,* where it was held that professionals should not be held out as "*paragons of virtue".*

IMPAIRMENT

152. Although the Committee's determination must focus on the present position, that is to say whether fitness to practise is currently impaired, it is clear from leading cases such as *Cheatle v General Medical Council [2009] EWHC 645* that in order to form a view as to current impairment, the Committee must take account of the way in which R1 has acted in the past, although a finding of misconduct in the past does not necessarily mean that there is impairment of fitness to practise today.

153. It was said in the case of *Cheatle:*

> "*the purpose of fitness to practise proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The Fitness to Practise Panel thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past...this means that the context of the doctor's behaviour must be examined. In circumstances where there is misconduct at a particular time, the issue becomes whether that misconduct, in the context of the doctor's behaviour both before the misconduct and to the present time, is such as to mean that his or her fitness to practise is impaired. The doctor's misconduct at a particular time may be so egregious that, looking forward, a panel is persuaded that the doctor is simply not fit to practise medicine without restrictions, or maybe at all. On the other hand, the doctor's misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practise Panel could conclude that, looking forward, his or her fitness to practise is not impaired, despite the misconduct."*

154. In the case of *Cohen v General Medical Council [2009] EWHC 581* Silber J set out the following guidance:

> "*It must be highly relevant in determining if a doctor's fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated."*

155. In the case of Yeong v GMC [2009] EWHC 1923 (Admin) Sales J said:

> "*in looking forward the Panel is required to take account of such matters as the insight of the practitioner into the source of his misconduct, and any remedial steps which have been taken and the risk of recurrence of such misconduct. It is required to have regard to evidence about matters that have arisen since the alleged misconduct occurred."*

156. In addition, in *CHRE v (1) NMC and (2) Grant [2011] EWHC 927 (Admin*) Cox J considered the case of Cohen and stated:

> "*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...When considering whether fitness to practise is currently impaired, the level of insight shown by the practitioner is central to a proper determination of that issue."*

157. R1's misconduct and dishonesty demonstrate an attitudinal shortcoming that is arguably difficult to remedy. In the case of *GMC v Chaudhary [2017] EWHC 251* it was said that:

"*dishonesty in a person does not have to be an all pervading or immutable trait. A person can be dishonest on just one occasion".*

158. In the present case R1 was repeatedly dishonest, in many different ways, over a prolonged period of time. However, in the case of *PSA for Health and Social Care and GMC v Uppal [2015] EWHC 1304,* it was held that *"even in cases of dishonesty a separate assessment of impairment is required and not every act of dishonesty results in impairment".* The Committee has therefore considered carefully the circumstances of this case, and in particular took into account R1's evidence at this hearing in order to decide if there is current impairment.

159. The Committee would describe the misconduct in this case as a litany of dishonesty, including misleading suppliers, forging fellow pharmacists' signatures, making up a story about a patient abroad, forging headed notepaper for a non-existent clinic, lying to two NHS Trusts and lying to the MHRA and the Council. The repeated dishonest acts took place between 2019 and 2021 and required a sophisticated level of planning and execution. For example, he carried out a search on Linkedin and the Council's register to find DC and AP.

160. The Committee accepted that there was no evidence of actual patient harm, but there was the potential for this, as R1 was attempting to purchase medication, which was in limited supply, to sell abroad, thus potentially depriving UK patients. Rule 5(2)(a) is therefore engaged.

161. Limbs (b) and (c) are clearly engaged, as R1's repeated dishonesty brought the reputation of the profession into disrepute and breached a fundamental tenet of the profession.

162. With regard to the issue of the Registrant's integrity, the Committee noted that in the *Wingate* case, it was said that:

"*In professional codes of conduct, 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.*

163. There is clear evidence that R1's integrity cannot be relied upon. He demonstrated a deep and sophisticated level of deception over a prolonged period of time, behaviour which fell well below the high standards expected from pharmacy professionals. The Committee did not consider that there has been sufficient evidence in the interim to persuade it otherwise. Rule 5(2)(d) is therefore also engaged.

164. The Committee then considered whether R1 had demonstrated sufficient remediation and concluded that he had not. He has provided one short piece of CPD, which he said he only prepared about a month ago. He has not undertaken any courses in relation to dishonesty or professional ethics. His reflections have been limited and have tended to focus on the impact these proceedings have had upon him. R1 has had three years to reflect on his actions, but the Committee is not persuaded that he has full insight into his wrongdoing. The Committee was not assured that the dishonest conduct was highly unlikely to be repeated. The Committee considered that if another opportunity arose, R1 might be tempted to act in a similar way again, in order to get ahead in business and achieve substantial profits.

165. The Committee also noted that R1 provided 10 positive testimonials. R1 told the Committee that a friend declined to give him a character reference once she knew about these proceedings. Although all of the emails containing the testimonials have the Particulars of Allegation on the same page, they are in a different font type, and it

was unclear to the Committee whether all of the people providing testimonials had seen them. It is also unclear whether R1 had told them that he had admitted most of the allegations. One customer stated, "*Such claims made against [R1] are nothing but libellous slander based on baseless assumptions regarding his intent…I would urge anyone who is reading this to please take a moment, and seriously think about the negative effect these legal disruptions that are baseless has on the wellbeing of the community as a whole as well as hard working members of the NHS such as Mr M Amier."* One locum pharmacist who is employed by R1 also provided a testimonial, but it appeared to the Committee that she may not have been advised of the nature of these proceedings, as she stated, *"I have seen the reasons for [R1]'s suspension from the register and I am writing this statement in support of R1."* A second locum pharmacist employed by R1 stated that they were *"aware of the reasons for his suspension from the register,"* which again indicates that they may not be aware of the nature of these proceedings. In light of this, the Committee attached limited weight to these testimonials.

166. The Committee has also taken into account the wider public interest criteria and the comments in the *Grant* case referred to above. Public confidence in the profession would be undermined if a finding of current impairment were not made, taking into account that the misconduct included repeated dishonesty. Members of the profession and the public would be shocked if a finding of current impairment were not made.

167. In light of all of these considerations, the Committee finds that R1's fitness to practise is currently impaired by reason of misconduct.

DECISION ON SANCTION

168. Having found impairment, the Committee went on to consider the matter of sanction. The Committee's powers are set out in Article 54(2) of the Order. The Committee should consider the available sanctions in ascending order from least restrictive, (i.e. take no action,) to most restrictive, (i.e. removal from the register,) in

order to identify the appropriate and proportionate sanction that meets the circumstances of the case.

169. The purpose of the sanction is not to be punitive, although 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 the promotion of professional standards. The Committee is therefore entitled to give greater weight to the public interest over R1's interests.

170. The Committee had regard to the Council's updated '*Good decision making: Fitness to practise hearings and sanctions guidance'* which came into effect on 25 March 2024 to inform its decision.

171. The Committee took into account the written and oral submissions made by Mr Ross and Mr Summerfield, and R1's oral additional evidence at this stage.

R1'S EVIDENCE

172. R1 gave additional evidence under oath at this stage. He maintained that he has always been completely honest in his dealings with his patients. He said that he feels really bad about bringing others into this case,(Redacted). He felt awful on the first day of this hearing to see so many people on the screen, including the Committee, all because of his actions.

173. R1 said that he feels that his health condition has been completely ignored. He said that if he can afford it, he intends to refer himself privately for treatment. He also gave evidence of how a sanction of suspension or removal would affect him and his family financially.

174. In answer to questions from the Committee, R1 said that he had not realised that there were courses available to pharmacists which dealt with dishonesty and ethics. Now that he knows about them, he intends to undertake this type of CPD.

COUNCIL'S SUBMISSIONS ON SANCTION

175. Having considered the Committee's determination on impairment, Mr Ross submitted that erasure is a sanction which the Committee should consider. He had taken the Committee through the aggravating and mitigating features which it should balance in order to come to a decision on sanction. He referred to quotes from various cases, where it was said that there was "*no room for a dishonest doctor"* and *"a finding of dishonesty lies at the top of the spectrum of misconduct".*

R1'S SUBMISSIONS ON SANCTION

176. Mr Summerfield conceded that a warning is unlikely to be a sufficient sanction to mark the seriousness of the misconduct. He also agreed with the Council that conditions of practice would not be appropriate for a case involving honesty.

177. Mr Summerfield submitted that the appropriate order in this case would be suspension. He reminded the Committee that the misconduct took place four years ago, and there has been no repetition since. He said that his client has cooperated with the MHRA and the Council, made early admissions and has shown genuine remorse. He submitted that an order of suspension would give R1 the time to develop further insight into how his actions impacted on the profession and the public. He said that an order for removal would not benefit R1, the public or the profession, and would permanently deprive patients of the services of a good pharmacist.

178. In his skeleton argument, Mr Summerfield submitted that the length of any suspension order should be proportionate to the objective sought by such a sanction.

DECISION ON SANCTION

179. In a line of authorities traced back to the case of *Bolton v the Law Society [1994] 1 W.L.R. 512,* it has been observed that personal circumstances and mitigation may count for less in regulatory proceedings than they would, for example, in criminal proceedings.

180. The Council's *Good decision making* guidance contains particular guidance in cases involving dishonesty. Paragraph 6.8 states:

"*Regulators ensure that public confidence in a profession is maintained. This is a long established principle and our standards state that registrants should act with honesty and integrity to maintain public trust and confidence in the profession. There are some acts which, while not presenting a direct risk to the public, are so serious they undermine confidence in the profession as a whole. The GPhC believes that dishonesty damages public confidence, and undermines the integrity of pharmacists and pharmacy technicians. However, cases involving dishonesty can be complicated – committees should carefully consider the context and circumstances in which the dishonesty took place. Therefore, although serious, there is not a presumption of removal in all cases involving dishonesty.*

181. In addition, paragraph 6.9 states:

"Some acts of dishonesty are so serious that the committee should consider removal as the only proportionate and appropriate sanction. This includes allegations that involve intentionally defrauding the NHS or an employer, falsifying patient records, or dishonesty in clinical drug trials".

182. In R1's case the Committee has found that the dishonesty was repeated, and included falsifying documents using the names of AP and R2, and falsifying patient

information to produce to DC. He also repeatedly provided false prescriptions to his suppliers, stating that they were for genuine patients, when he knew that this was untrue. However, this case did not involve defrauding the NHS or an employer. In addition, actual patient records were not falsified, but rather R1 made the prescriptions look like they were genuine. This is not a case where false information made its way to patients' medical records.

183. Paragraph 6.10 of the guidance states:

"When deciding on the appropriate sanction in a case involving dishonesty, the committee should balance all the relevant issues, including any aggravating and mitigating factors. It is important to understand the context in which the dishonest act took place and make a decision considering the key factors. The committee should then put proper emphasis on the effect a finding of dishonesty has on public confidence in the profession".

184. The Committee identified the following aggravating factors:

- R1's dishonesty was premeditated, going to extraordinary lengths such as drafting a false SLA, inventing a patient in the Middle East and creating a false doctor's letter.
- The dishonesty was for personal, financial gain.
- The dishonesty was repeated over the course of two to three years.
- The dishonesty took many forms and in different settings.
- R1 has only shown limited insight into his misconduct.

185. The Committee identified the following mitigating features:

- R1 has demonstrated remorse
- R1 admitted the majority of his wrongdoing, including dishonesty, prior to this hearing

- R1 has no previous fitness to practise findings
- R1 has shown some insight into his misconduct
- R1 has provided testimonials from patients which make clear that he is well thought of as a pharmacist and is providing a valuable service to the community.

186. [PRIVATE]

187. The Committee decided that either taking no action or giving a warning would be inadequate responses to such serious misconduct. The public interest would not be served. In addition, a warning is not appropriate where there is a risk of repetition.

188. The Committee next considered the imposition of conditions of practice. A conditions of practice order would allow R1 to practise, albeit with restrictions. Conditions of practice are more appropriate in cases where there is some deficiency in a registrant's practice which would be addressed by conditions. That is not the case here. The risk of repetition stems from the Registrant's limited insight into what drove him to act in the way he did, and conditions of practice cannot address that issue. The Committee also could not formulate conditions of practice which would address dishonesty. In addition, the Committee considered that conditions would not be sufficient to mark the seriousness of the matter so as to maintain public confidence in R1, the profession and the regulator, nor sufficient to promote professional standards within the profession.

189. The Committee next considered whether suspension would be a proportionate sanction. The Committee noted the Council's guidance which indicates 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 to 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."*

190. The Committee also took into account the Council's guidance on dishonesty as set out above, noting that it should "*put proper emphasis on the effect a finding of dishonesty has on public confidence in the profession".*

191. R1 had provided in his bundle a copy of "*Dishonest behaviour by health and care professionals: Exploring the views of the general public and professionals",* a report prepared for the PSA, following interviews with eight focus groups containing both professionals and members of the public. In his submissions on impairment Mr Summerfield had invited the Committee to consider this report in order to decide where, on a scale, his client's dishonestly lay. This outlined 12 aggravating factors in professional dishonesty cases. The Committee considered that R1's case engaged five of these, namely the potential for personal financial gain, systematic or longstanding, premeditated, complexity of deceit and direct threat to confidence in the profession. However, it did not involve the top three aggravating features, namely predatory behaviour, misuse of power or vulnerable victims, or other factors further down the list, including direct harm to patients. The Committee has found that the misconduct did not present as a direct threat to patient safety.

192. The Executive Summary of the PSA report also contained the following observations:

- The tendency was towards an emphasis on behaviour change and learning and rehabilitative and constructive outcomes, which allowed registrants to continue in the profession. This was particularly the case where individuals

showed insight and remorse and seemed willing and capable of changing their behaviour.

- Full disclosure, remorse and insight as to why dishonest behaviour was unacceptable and willingness to learn and change were seen as powerful mitigating factors.

193. The Committee has already remarked in its findings on impairment that this case involves serious misconduct which brought the profession into disrepute. The public interest, specifically confidence in the profession and upholding proper standards of behaviour, suggests that there should be a severe sanction at the top end in this case. In reality, the appropriate options for this Committee are suspension or removal from the register.

194. The Committee next considered suspension for up to 12 months. The public would be protected as R1 would not be able to practise whilst suspended, but this case was never really about public protection, as there was never any direct risk to patient safety.

195. The sanctions guidance states that some acts of dishonesty are so serious that removal is the only appropriate and proportionate response, but the Committee has noted that R1's dishonesty did not come within those categories (e.g. NHS fraud etc). The Committee thought very carefully about whether R1's behaviour was so egregious that he should be removed from the register, and it was a finely balanced decision. However, taking into account the mitigating factors, and the fact that the dishonesty did not impact patient safety, or involve defrauding the NHS or an employer, the Committee has decided that the misconduct falls just short of requiring the ultimate sanction of removal from the register. The main reason that the Committee ultimately decided against removal from the register was that R1's dishonesty did not put the public at a real risk of harm. The Committee has also seen

the positive references from patients confirming that the Registrant is an excellent clinician and has a lot to offer the profession. Patients would be permanently deprived of the services of R1 if he was removed from the register, and that would not be in the public interest. The Committee has therefore decided that, in this case, a period of suspension is the appropriate sanction in this case. This sanction will be sufficient to mark the public interest, but the period of suspension will be for the maximum period of 12 months with a review, to reflect the seriousness of the misconduct. This will send a message out to the profession and the public that serious, premeditated and repeated dishonestly will not be tolerated.

196. A suspension for 12 months will also provide R1 with an opportunity to develop his insight into how his actions impacted on the public and the profession. The Committee wishes to make it clear to R1 that he has much work to do, and he will need to dedicate time and energy if he is to persuade the reviewing committee that his fitness to practise is no longer impaired.

197. The Committee acknowledged that this sanction will have an adverse effect on R1 as he will not be permitted to practise as a pharmacist for the next 12 months. However, the case law makes clear that the public interest outweighs the interest of any individual registrant.

198. There will be a review towards the end of the 12 months suspension. This Committee cannot bind the reviewing committee, but considers that it is likely to be assisted by:

- R1 providing a detailed written reflection on this Committee's findings
- Evidence of comprehensive CPD and training R1 has undertaken regarding honesty, ethics and professionalism, including what he has learned from them

- Evidence that R1 has sought and undertaken treatment for, and/or strategies to manage, his health condition, including what action he has taken to minimise the effect of his impulsivity
- R1 finding a mentor with whom he can discuss this Committee's findings and to assist with his journey through his period of suspension

DECISION ON INTERIM MEASURES

199. The Committee's substantive decision will not take effect until 28 days after notice of this decision has been sent to R1, or until any appeal has been finally disposed of.

200. Mr Ross made an application for a suspension order to be imposed to cover that period, on the grounds that this was necessary to protect the public and was otherwise in the public interest.

201. The Committee took account of the Council's *Good decision making* guidance of March 2024, which states that interim measures can be imposed on the grounds that they are necessary to protect the public, and/or are otherwise in the public interest, and/or are in the interests of a registrant.

202. Mr Summerfield objected to the application. He referred to the case of *Aga v General Dental Council [2023] EWHC 3208 (Admin)* which is a High Court decision from 13 December 2023. In that case the judge decided that when a substantive direction for suspension is made, and an immediate suspension order is made, there is only one suspension made under the Dentists Act 1094. Mr Summerfield said that this decision applied to R1's case and means that this Committee is not entitled to make an interim suspension order, as it has already made a substantive suspension order for the maximum period permitted of 12 months.

203. Mr Summerfield also submitted that R1 needs time to "*get his house in order",* which includes arranging for locums to cover his shifts at his pharmacies. He said that although R1 has been able to make tentative arrangements for some locum cover, he is finding it difficult to find full cover.

204. The Committee decided to impose an interim suspension order.

205. Dealing first with the case of *Aga,* the Committee noted that this was a decision made in relation to a different healthcare regulator, interpreting its own legislation, rules and guidance. The Committee noted that the decision is currently the subject of an appeal. The Committee also noted that the General Pharmaceutical Council's own updated *Good decision making guidance,* which came into effect on the day this application was made, refers to the Committee's powers to impose immediate measures following sanction under Article 60 of the Pharmacy Order 2010. This guidance was therefore updated after the *Aga* decision was handed down last year.

206. The Committee recognised that the power to impose interim measures is discretionary and that the imposition of such measures is not an automatic outcome of fitness to practise proceedings in which a suspension order has been imposed. The Committee took into consideration the impact such measures may have on R1, although noted that he has two pharmacies and is used to employing locums. However, the Committee was mindful of its findings regarding R1's limited insight and the risk of repetition of dishonesty. In the circumstances, it considered that not to impose interim measures would be inconsistent with its finding that a substantive suspension order for the maximum period permitted is required. Public confidence in the profession and the regulatory process would be harmed if the Registrant were not made subject to an interim order during the appeal period.

207. The Committee therefore directs that the interim measure of suspension is put in place, as this is otherwise in the public interest. The measures will expire (if no appeal is made against the substantive decision) upon the expiry of the period during which such an appeal could be made. If an appeal is made, the measures will expire upon the final determination of that appeal.