General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

In person at General Pharmaceutical Council

1 Cabot Square, Canary Wharf, London E14 4QJ

7-10 May 2024

Registrant name:	Izabella Polyak
Registration number:	2069869
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	David Bleiman (Chair)
	Raj Parekh (Registrant member)
	Wendy Golding (Lay member)
Legal Adviser:	John Donnelly
Committee Secretary:	Sameen Ahmed
Registrant:	Present and represented by Elena Margetts, Counsel
General Pharmaceutical Council:	Represented by Yesim Hall, Case Presenter
Facts proved by admission:	All
Fitness to practise:	Impaired
Outcome:	Warning

Particulars of Allegation (as amended)

You being a registered pharmacist and whilst working at Millennium Pharmacy 68-70 Brixton Road, Brixton, London SW9 6BH

(1) On or around 1 September 2020 you supplied Baby A with Morphine Sulfate 10mg/5ml oral solution (100ml).

(2) On or around 01 September 2020 you failed to:

(2.1) Correctly label and/or ensure that the Morphine Sulphate was correctly labelled in that the label stated it was 100mcg/ml and 10mg/5ml

(2.2) Explain and/or advise Baby A's parent that the Morphine Sulphate being supplied was 10mg/5ml and not 100mcg/ml

(2.3) Take any or sufficient steps to ensure that Baby A's parent understood the correct volume of Morphine Sulphate which should be administered to Baby A in light of the fact it was 10mg/5ml

(2.4) Write the volume of Morphine Sulphate to be administered on the prescription label

(3) On or around 28 August 2020 you did not check the concentration of the prescribed Morphine Sulphate and/or dosage instruction with the prescriber in light of the fact that the prescription incorrectly stated two different concentrations.

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

Documentation

Document 1- Hearing bundle (231 pages)

Document 2- GPhC skeleton argument (17 pages)

Document 3- Testimonial from A.T. dated 1 May 2024 (1 page)

Document 4- Testimonial from A.S. dated 5 May 2024 (1 page)

Document 5- Testimonial from M.O. dated 3 May 2024 (1 page)

Document 6- CPPE certificate for learning programme in Opioids, 7 June 2021 (1 page)

Document 7- Testimonial from O.M-S. dated 5 May 2024

Document 8- Testimonial from F.B. dated 8 May 2024

Document 9- Five further CPPE certificates for study undertaken between November 2020 and August 2023

Witnesses

Witness B, Director of Quality, SE London Clinical Commissioning Group- witness statement dated 28 January 2022.

Witness C, Lead Pharmacy Adviser, Medical & Digital Transformation Directorate, NHS England & NHS Improvement, London Region- witness statement dated 5 May 2022.

Mother of Baby A – witness statement dated 25 July 2023 admitted as hearsay evidence.

Father of Baby A – witness statement dated 25 July 2023 admitted as hearsay evidence.

Witness D, GPhC Casework Manager- witness statement dated 17 April 2024.

Izabella Polyak, registrant- witness statements dated 27 May 2021 (for Council) and 20 July 2023 (for Southwark Coroners Court).

Introduction

1. This is the written determination of the Fitness to Practise Committee at the General Pharmaceutical Council (‘the Council’).

2. The hearing is governed by The Pharmacy Order 2010 (“the Order”) and The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010 (“the Rules”).

3. The statutory overarching objectives for these regulatory proceedings are:
   A) To protect, promote and maintain the health, safety and well-being of the public;
   B) To promote and maintain public confidence in the professions regulated by the Council; and
   C) To promote and maintain proper professional standards and conduct for members of those professions.

4. The Committee also has regard to the guidance contained in the Council’s Good decision making: Fitness to practise hearings and sanction guidance as revised March 2024 (“the guidance”).

5. A Principal Hearing has up to three stages:

   Stage 1. Findings of Fact – the Committee determines any disputed facts.
   Stage 2. Findings of ground(s) of impairment and impairment – the Committee determines whether, on the facts as proved, a statutory ground for impairment is established and, if so, whether the Registrant’s fitness to practise is currently impaired.
   Stage 3. Sanction – the Committee considers what, if any, sanction should be applied if the Registrant’s fitness to practise is found to be impaired.

Application to amend the particulars of allegation

6. The committee heard an application from Ms Hall under Rule 41 to amend allegation 2.1 to delete the word “not”. The Council accepted that the bottle and box of Morphine Sulphate concerned was labelled with both doses, namely 100 mcg/ml and 10 mg/ 5ml. It was submitted that the amendment reflected the evidence

contained within the case bundle and so would not prejudice the fairness of the proceedings.

7. Miss Margetts agreed with the proposed amendment.

8. We accepted legal advice.

9. We agreed that there would be no prejudice to the fairness of the proceedings by making the amendment and we agreed to the amendment.

10. The wording of the allegations, as amended, is provided above.

Registrant's response to Particulars of allegation

11. The allegations, as amended, were read into the record and Miss Polyak was asked if she wished to make any admissions.

12. Miss Polyak admitted all of the particulars of allegation.

13. In the light of the above, and by the application of Rule 31(6) of the Rules, the facts were all found proved.

Applications to admit further evidence

14. Miss Hall made an application for a witness statement of Witness A, a Pharmacy Adviser to the Council, to be admitted into evidence. She submitted that Witness A was not presented as an expert witness but was a fellow pharmacy professional who gave her opinion informed by experience. The witness statement had been available to Miss Polyak since December. She cited the case of *Hoyle v Rogers, 2014 EWCA Civ 257* as authority that an investigator's opinion report was admissible.

15. Miss Margetts submitted that the witness statement was plainly presented as expert evidence. The Council had made clear in its listing questionnaire that it would not be calling expert evidence. Witness A had had no involvement in the case, was not a witness of fact but provided commentary on the evidence without being an independent expert and providing the appropriate certification of such independence.

16. We asked for sight of the witness statement prior to deliberating on the application. Miss Margetts submitted that it would be prejudicial for us to see the document.

17. We accepted legal advice which referenced the case of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)* in which the High Court found that a panel should have sight of all the necessary material when conducting a balancing exercise.

18. We decided on the preliminary point that we agreed to the legal advice and should have sight of the statement before deciding whether it was admissible. We decided that, as an expert and trained panel, we would be able to put the contents of the statement out of our minds if we decided not to admit it in evidence.

19. After reading the statement, we heard further submissions and accepted further legal advice. We accepted that the test for admissibility of evidence under Rule 24 was one of relevance and fairness.

20. We decided that it would not be fair to admit the witness statement of Witness A. She was clearly not a witness of fact. Nor was she a Council investigator who had knowledge of the facts and could report on the outcome of her investigations. Her statement was clearly one of opinion. Much of it related to a specific matter which was not part of the allegations. She was not an independent expert. She was a pharmacy adviser to the Council. It would be prejudicial to Miss Polyak to admit the

witness statement and, taking into account fairness to both parties, it would be unfair to admit the statement.

21. We assured Miss Polyak that we could and would put the contents of the statement out of our minds.

22. Two further uncontested applications were made by Miss Margetts. She applied for five documents to be admitted into evidence on behalf of Miss Polyak. We agreed that the documents, comprising four testimonials and a certificate, be admitted into evidence. These are as listed in the Documentation section above. During our deliberations, Miss Margetts provided one further testimonial and five further CPPE certificates. With the agreement of Miss Hall we took these into account before concluding our deliberations.

Redactions

23. We agreed to an uncontested application to redact paragraph 11 of the witness statement of Witness B and paragraphs 23 and 25 of the witness statement of Witness C.

24. On our own initiative and with the agreement of the parties, we redacted the name of Baby A which had, through a slip, appeared unredacted on page 223 of the case bundle.

Clarification of redacted name

25. We clarified that the person referred to in a redacted form as “Milennium Pharmacy Contributor” in the witness statement of Witness C, was a person we refer to as B.O.

Weight to be given to evidence

26. Miss Margetts submitted that, while Miss Polyak had agreed that the witness statement of the father of Baby A be admitted as hearsay evidence, we should give less weight to that evidence in relation to a matter which was not agreed by Miss Polyak. We should prefer her paragraphs 25 and 26 to his paragraphs 6, 7 and 8. We heard preliminary submissions in response from Miss Hall.

27. Miss Hall indicated that she would be making a submission on the weight to be attached to the new documentary evidence (testimonials and certificate) which had been admitted into evidence on the application of Miss Margetts.

28. Having accepted legal advice, we informed the parties that we would not decide the question of what weight to give particular items of evidence as a preliminary matter. They would be free to make submissions on this aspect as part of their closing submissions at this misconduct/impairment stage of the hearing.

Witness attendance

29. We heard from Miss Hall and Miss Margetts that neither of them had questions to put to the Council's witnesses. Having clarified matters we informed them that we had no questions of our own to put to the witnesses. We confirmed, with agreement of the parties, that all the Council witnesses could be released from giving evidence in person.

Background

30. Ms Izabella Polyak is a pharmacist first registered in Hungary in 1991 and then with the Royal Pharmaceutical Society of Great Britain on 28 May 2009, whose registration transferred to the Council under registration number 2069869.

31. At the time of the events, she was a pharmacist at Millenium Pharmacy, 68 – 70 Brixton Road, London (“the pharmacy”).

32. On 28 August 2020 the pharmacy received a prescription for Baby A, who had been discharged from the Evelina Hospital 8 days earlier for palliative care at home. Baby A was born with life-limiting cardiac and airway conditions. On discharge from hospital, Baby A was prescribed a number of medications which included Morphine Sulphate for pain relief.

33. The prescription for Morphine was for a “Special” category of unlicensed medicines that are provided specifically to meet the individual needs of a patient. The bottle labelled by the hospital on 14 August 2020 showed a concentration of Morphine of 100 mcg/ml, with instructions to administer 1.2 mls (120 mcg) instead of the printed 2.6 mls (260 mcg). According to Witness C, Morphine solution of this concentration (100 mcg/ml) is not an off the shelf product and has a short expiry. The parents therefore soon needed to obtain further supplies.

34. The prescription sent by the GP surgery to the pharmacy (through the Electronic Patient System (“EPS”) included two different concentrations of Morphine. One was for 10 mg/ 5 ml oral solution and the other for 100 mcg/ ml. This was an uncommon prescription request and, as Morphine Sulphate 100 mcg/ ml was not available on EMIS Formulary, a medical information service (“EMIS”), the pharmacy dispensed the 10 mg/5 ml oral solution.

35. Baby A’s father attended the pharmacy to pick up the medicine and, though there was discussion, Miss Polyak admits that she did not explain that the bottle contained the 10 mg/5 ml solution.

36. Baby A’s mother gave 1.5 mls of the medication to Baby A, thinking that it was the same medication as that provided by the hospital. The baby became unresponsive and was taken by ambulance to hospital where tragically she died a few days later.

37. An inquest was held at Southwark Coroners Court on 27 July 2023. The coroner concluded as follows as regards the causes of Baby A's death:

    She died of a combination of natural disease and accident. The failures of both the GP and pharmacist to make further enquiries to ensure the medication administration was safe related in part to the workload pressures of the pandemic. But they contributed to the death, as the child was given a more concentrated form of Morphine which delivered twenty times the intended dose. Baby A was very fragile with limited life expectancy, but would not have died when she did, without the overdose, naturally having less reserve to recover from the intoxication.

38. On 18 August 2023 the Senior Coroner who conducted the inquest completed a Regulation 28 report to prevent future deaths. The report noted that, whilst the GP and pharmacist had made errors in clinical practice and had not contacted each other, *the error would not have occurred had another strength of morphine been a choice on EMIS*. He understood that a similar incident had occurred in the North of England and that lessons (from the incident affecting Baby A) had not been applied there.

39. The Senior Coroner notified EMIS with a view to the special prescription being added to its database. He requested action by NHS England to prevent future deaths by ensuring that the whole of the NHS saw the benefits of local health economy wide paediatric prescribing policies.

40. On 13 November 2023 the National Medical Director for NHS England responded to the Regulation 28 report, stating that national work was underway by paediatric experts to consider what needed to be done to reduce the likelihood of a repetition of the circumstances seen in this case. He noted that there had been three serious incidents in the last three years where an incorrect oral morphine preparation was prescribed and dispensed to a baby. There was a lack of awareness and clarity over a medicine being a special preparation as well as poor communication between medical professionals and parents of the child.

Misconduct and Impairment

41. Having found all particulars of the allegations proved, we went on to consider whether the particulars found proved amounted to misconduct and, if so, whether Miss Polyak's fitness to practise is currently impaired.

42. We took account of the guidance given on the meaning of 'fitness to practise' in the guidance. Paragraph 2.12 reads:

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

43. We took into account the submissions from Miss Hall for the Council and Miss Margetts on behalf of Miss Polyak.

44. Miss Hall submitted that we should prefer the evidence of the father of baby A to that of Miss Polyak in respect of aspects which were contested. Miss Margetts submitted that we should prefer Miss Polyak's evidence. Neither party submitted that the matters in dispute were significant in relation to the seriousness of Miss Polyak's admitted actions. In the context that Miss Polyak has conceded misconduct we did not find it necessary to make a factual finding on the limited areas of dispute, which do not materially impact on the seriousness of her conduct, either way.

45. Miss Hall submitted that Miss Polyak's failures were extensive and amounted to a breach of the Council's *Standards for Pharmacy Professionals*, May 2017 ("the Standards") in relation to Standards 2, 5 and 9.

46. Miss Hall submitted that an email sent by the pharmacy (not by Miss Polyak herself) on 20 May 2021 and a root cause analysis undertaken by Miss Polyak on 18 January 2021 showed a lack of insight. She submitted that the errors were so basic that it should not have taken her until her witness statement of July 2023 to show insight and that this, together with her not being open to cross-examination, cast doubt on the validity of her insight. Miss Hall questioned whether Miss Polyak had undertaken adequate remediation. She invited us to exercise caution when looking at testimonials in which there was not explicit reference to the allegations before us.

47. Miss Margetts said that Miss Polyak relied on her two witness statements and in particular the statement of 27 July 2023 prepared for the inquest held at the Southwark Coroners Court. She submitted that Miss Polyak conceded misconduct. In response to our questions, she took instructions and responded that Miss Polyak conceded that she had breached the Standards in respect of Standards 2 and 5. Standard 9 had an overlap with Standard 5 and it was not conceded that there had been a free-standing breach of Standard 9.

48. In relation to impairment, Miss Margetts submitted that there had been a single isolated clinical incident, that there had been no repetition and there was no risk of repetition, that Miss Polyak had shown insight, that she had remediated her misconduct and that the positive testimonials should be given weight and taken into account. Miss Margetts submitted that, in relation to the wider public interest, the admitted seriousness of the isolated errors in this case was insufficient to amount to a public interest ground for finding impairment.

49. We accepted the advice of the legal adviser.

Decision on misconduct

50. When considering whether the particulars found proved amounted to misconduct we took into account the guidance.

51. Miss Polyak's errors, albeit they took place in relation to one patient, baby A, and over a short period of time, were of a serious nature and, as we have noted above in the findings of the Coroner, her errors, together with those of the GP who wrote the prescription, "contributed to the death" of the child at a sooner date than would otherwise have occurred.

52. We considered that Miss Polyak had breached the Standards. The core of the Standards is the expectation that pharmacists will provide "safe and effective care" and that was not achieved in relation to the care of baby A. We agree with Miss Hall and Miss Margetts that Standards 2 and 5 were breached. We also found a breach of Standards 1 and 3 and, insofar as it overlaps with Standard 5, a breach also of Standard 9. The breaches may be summarised as follows:
    (a) Standard 1 requires person-centred care, which was not achieved in this case involving a very vulnerable baby requiring an unusual treatment;
    (b) Standard 2 requires working in partnership with others, which was not achieved in relation to working with the GP and with the parents;
    (c) Standard 3 regarding communicating effectively was not achieved in relation to the father of baby A;
    (d) Standard 5 regarding use of professional judgement was not achieved in respect of the quality of clinical decision making;
    (e) Standard 9 regarding leadership was not achieved in relation to assessing risks.

53. We bore in mind that the Standards may be taken into account when considering the issues of grounds and impairment but that a breach of the Standards does not automatically result in a finding of misconduct (Rule 24(11) of the Rules).

54. We concluded that, in our judgement and for the reasons set out above, the ground of misconduct is established. We therefore went on to consider whether Miss Polyak's fitness to practise is impaired.

Decision on Impairment

55. We gave careful consideration to the matters listed in Rule 5 (2) and to whether the particulars found proved show that Miss Polyak:

    • *presents an actual or potential risk to patients or to the public*

    • *has brought, or might bring, the profession of pharmacy into disrepute*

    • *has breached one of the fundamental principles of the profession of pharmacy*

    We note that there is no concern relating to Miss Polyak's honesty or integrity.

56. We began by looking at the question of whether there is a risk to patients of the public.

57. Miss Polyak has a long career as a pharmacist, having registered in Hungary in 1991 and in Great Britain in 2009. When she moved to Britain in 2008 she chose to work initially as a trainee, although her qualifications would at that time have been accepted by the regulator. She has been employed since 2009 by the pharmacy, moving to different branches in August 2022 and then January 2023, where she is currently working as a senior pharmacist.

58. Miss Polyak has no record of fitness to practise concerns either before or after the events concerned in this case. She has been working for more than three years in a full-time capacity as a pharmacist.

59. We are satisfied that, although we have found more than one error, all of the facts found relate to a single prescription affecting a single patient and that this can properly be regarded as an isolated, albeit serious, series of errors.

60. Miss Polyak has been working without restriction for more than three years, which suggests that her safe practice has not been a matter of urgent concern over this time. In any event, she has not given any further cause for concern.

61. We consider that Miss Polyak has shown a highly developed insight into her misconduct. We do not accept that she should be judged today by reference to any limitations in her level of insight in 2021. Insight can develop with time and reflection and it is proper to have regard to the most recent witness statement of July 2023, supported by Miss Polyak's admission of all the allegations at the outset of this hearing and her concessions as regards misconduct and a breach of some of the Standards. We accept the legal advice that insight is defined by how a registrant would behave if faced with the same set of circumstances today. We do not hold against Miss Polyak that she exercised her right not to give evidence in person. Although she could not be cross-examined she was open to questions from the committee and we were indeed assisted by her answers.

62. In her July 2023 witness statement, Miss Polyak acknowledged a number of her errors. She did not consult the GP but recognised that that there were a number of abnormalities with the prescription which should have led her to do so prior to dispensing the prescription. She acknowledged that she had misread the second line of the prescription as a direction to administer between 100 and 120 mcg to the patient every six hours, but now realised that the second line was a different concentration and was followed by the directions for administering. She accepted that this was confusing and unusual and that she should have contacted the GP to clarify the concentration prior to dispensing the prescription.

63. In the July 2023 witness statement, Miss Polyak offered deepest sympathies to the patient's family and offered her heartfelt apologies to them.

64. In addition to the insight which we have found, we consider that Miss Polyak has remediated her practice by making appropriate changes to her working methods and environment. She no longer takes phone calls during the prescription process, to avoid interruptions and becoming distracted. A trainee now assists her with her work, which helps to reduce pressure during busy periods and makes it easier to obtain a second opinion when required. She spends longer to check each prescription and discuss instructions with patients whenever necessary, regardless of

whether there is a queue. She has a direct line to the GP surgery, so that she can raise questions with prescribers quickly and without having to go through reception staff. She now reviews and adds volume to prescriptions where they have been issued by weight to ensure that the patient is clear on the amount to administer.

65. Miss Polyak undertook CPPE training in June 2021 in relation to opioids. We accept that this was relevant training, as her errors related to Morphine Sulphate, an opioid. She has provided five CPPE certificates for further study undertaken, one dated 16 November 2020 and the others dated August 2023. We find these also to be relevant, in particular those relating to clinical calculations for pharmacy professionals and to themes concerning controlled drugs.

66. Miss Polyak has moved to a branch of the pharmacy which is less busy and where she is less pressured.

67. In the aftermath of the tragic death of baby A, Miss Polyak was involved in discussions with colleagues and worked with the Superintendent Pharmacist to review the SOPs.

68. We have considered the five recent testimonials provided on behalf of Miss Polyak. Although the specific allegations are not referred to in terms, four of the testimonials refer in one way or another to the incidents and we are content that those providing these testimonials understood, at least in general terms, the nature of the concerns in this case. The testimonials are professional references from two pharmacists, two dispensers and a business manager, all of whom show knowledge of Miss Polyak's practice and express confidence in her care and safety as a pharmacist. The testimonials do not stand in isolation but are supportive of the evidence of her safe working practices by the lack of any concerns before and especially since the concerns in this case.

69. For all of the above reasons we are satisfied that Miss Polyak does not pose a risk to patients or the public and there is no public protection ground for finding her fitness to practise impaired.

70. We turned to consideration of whether Miss Polyak's fitness to practise should be found to be impaired in the wider public interest.

71. It is accepted in professional regulation, that the fundamental principles of the profession may be found in the Standards. We have found (indeed we give Miss Polyak some credit for having conceded) that she has breached the Standards. The core of the Standards is to provide safe and effective care and she failed to do that in relation to baby A.

72. We are satisfied that there is not a risk, going forwards, that Miss Polyak will bring the reputation of the profession into disrepute. However, we find that she has done so by her historic misconduct.

73. Miss Polyak's errors were only one part of a series of issues which combined to result in the death of baby A. We have noted that the Coroner reported that *the error would not have occurred had another strength of morphine been a choice on EMIS.* We note that this was not the only incident of this kind and that NHS England has given consideration to the need for systemic improvements to avoid repetition. It is clear that the GP, as the prescriber, made errors and that both Miss Polyak and the GP shared responsibility for a lack of effective communication. We note that, in this instance, Miss Polyak was the dispenser and the medicine was checked by a colleague. The errors occurred during the COVID pandemic and when Miss Polyak was working in a pressured environment. Nonetheless, her errors were one of the contributory causes of the death of baby A and, as such, had a negative impact on the reputation of the pharmacy profession. A fully informed and reasonable member of the public would be shocked if a finding of impairment were not made in all of these circumstances.

74. For all of the above reasons, we find that it is necessary to declare and uphold the Standards and to maintain public confidence in the profession, that we find Miss Polyak's fitness to practise to be impaired in the wider public interest.

75. We must therefore proceed to hear submissions and consider what, if any, sanction is necessary and proportionate in this case.

76. Note of correction. After handing down our decision on impairment, we were notified of a slip in paragraph 68 above. In line 2 the words "four of" should be deleted. Miss Margetts identified this slip, Miss Hall did not object to the correction, and we corrected the slip. We found that all five testimonials referred in one way or another to the incidents.

Sanction

77. We heard submissions from Miss Hall and Miss Margetts and accepted legal advice on the question of what, if any, sanction would be appropriate and proportionate in this case. We had regard to the guidance. We relied on our earlier findings of fact and in relation to misconduct and our finding that Miss Polyak's impairment was on the grounds of the wider public interest alone.

78. Miss Hall sought a suspension for a period of three months.

79. Miss Hall suggested a number of mitigating factors. The aggravating factors she identified were that there was more than one failure, albeit in one incident, and that Miss Polyak had failed to learn from her mistakes in a timely manner. Miss Hall submitted that the public would be concerned about this delay in developing insight.

80. We find that the fact of a number of errors is inherent in the particulars found proved. This cannot therefore aggravate those failures. In any event, we have found this to be an isolated, albeit serious, series of errors.

81. We rely on our earlier findings as to insight. Miss Polyak had developed a high level of insight by the time of her witness statement for the inquest, signed in July 2023. She maintained her insight before us, as demonstrated by her admission of all the allegations, her concession as regards misconduct and her concession that she had breached some of the Standards. We note that we identified some breaches of the Standards which were not raised by Miss Hall, so that Miss Polyak did not have the opportunity to consider whether or not she agreed with our subsequent specific citation of Standards. We are satisfied that Miss Polyak accepts that she did not provide safe and effective care to baby A, which is at the heart of the Standards.

82. Pharmacy, in common with other healthcare professions, is a learning profession in which the development of insight is to be encouraged. Consequently, there is no time limit on the development of insight. Miss Polyak's highly developed insight has been demonstrated and sustained since at least July 2023. As to the level of her insight before that date, there is limited evidence before us. We are not persuaded that the timeline over which insight was developed is a material matter which could be regarded as an aggravating factor. We again rely on the legal advice that insight is to be defined as how a professional faced with similar circumstances would now behave. It is to be evaluated currently.

83. Miss Margetts submitted that a warning would be the proportionate outcome in this case. She reviewed Miss Polyak's insight and behaviour, the context of the incident, the content of the testimonials and the potential impact of a more severe sanction of suspension. She informed us that Miss Polyak's employer was unable to confirm whether her employment would still be available in the event of a period of suspension. She submitted that a warning would meet the same aims as a suspension. A suspension would have a negative impact on a pharmacy which was under pressure because of staff shortages.

84. We considered the following to be the aggravating factor in this case:

- Miss Polyak's errors exposed baby A to an unwarranted added risk of harm, in addition to the risks already faced by the vulnerable infant.

85. We considered that there were a number of mitigating factors:

- Miss Polyak has a long career as a pharmacist with no previous fitness to practice concerns.
- There have been no concerns since the incidents, during a period of unrestricted practice, her diligent and safe working practices being confirmed in testimonials from colleagues who know her work.
- In her July 2023 witness statement Miss Polyak identified and acknowledged her own failings.
- She has sought to limit future risk by taking appropriate remedial actions and undertaking appropriate training.
- Miss Polyak made full admissions at the outset of this hearing, conceded misconduct and conceded breaches of the Standards.
- The wider context of her errors included a system-wide lack of awareness identified by the Senior Coroner and by the National Medical Director for NHS England regarding a "special" medication, together with limited information available to Miss Polyak at the time, including the lack of a discharge letter from the hospital, as well as errors made by the prescribing GP.

86. We considered the outcomes available in ascending order of severity. We considered that to take no action would not declare and uphold the Standards which we have found were breached by Miss Polyak, nor sufficiently uphold public confidence in the profession.

87. We consider that a warning is the appropriate and proportionate sanction. We rely on the guidance that a warning may apply where there is a need to demonstrate to a professional, and more widely to the profession and the public, that the conduct fell

below acceptable standards, but where there is no continuing risk to patients or the public.

88. We looked at the more severe sanctions available. Conditions placing restrictions on Miss Polyak's practice are clearly unsuitable, as she poses no risk to the public and has been working safely unrestricted with no concerns.

89. Suspension would be an alternative to a warning. It would apply where a warning is deemed insufficient to maintain public confidence. We are satisfied that suspension would be wholly disproportionate in this case. It would have the effect of depriving the community of the services of a competent and dedicated pharmacist who practices safely and has been doing so without any restriction for more than three years since the isolated series of errors concerned in this case.

90. We had regard to the Council's publication and disclosure policy which sets out that a warning will appear on the online register, with our determination or a summary attached, for a period of one year. We are satisfied that this will provide an adequate public declaration to uphold the Standards and mark Miss Polyak's breach of the Standards, thereby sufficing to uphold public confidence in the profession.

91. This is a case in which, because of the extent of Miss Polyak's insight, she is not in need of a warning to rectify conduct which she has already rectified. But we are mindful of the guidance that a warning is also (and in the circumstances of this case, is mainly) to send a message to the wider profession and to the public about the need to uphold the Standards. We have taken care to word the warning carefully so as not to do unnecessary harm to Miss Polyak's career or prejudice her ongoing service to the community as a pharmacist.

92. We direct that a warning be issued to Miss Polyak in the following terms:

The Standards for Pharmacy Professionals exist to ensure safe and effective care to patients. Your failures in relation to the supply of a medicine to a baby on or around 28 August 2020 and 1 September 2020 have been found to amount to misconduct and you have been found to have breached these Standards.

You have shown insight into your misconduct, have taken remedial measures and have been found to pose no current risk to patients. You have been practising safely both before and since these isolated failures and it has not been found necessary to restrict your practice in any way.

The purpose of this warning is to mark the seriousness of the issue, to remind the wider pharmacy profession of the Standards which they are expected to meet at all times and to uphold public confidence in the profession.

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

93. That concludes this determination.