General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote videolink hearing

Monday 11 – Wednesday 13 December 2023

Monday 3 June 2024

Registrant name:	Jennie Dawn Collins
Registration number:	5101512
Part of the register:	Pharmacy Technician
Type of Case:	Misconduct
Committee Members:	Angela Black (Chair) Stephen Simbler (Registrant Member) Claire Bonnet (Lay Member)
Committee Secretary:	Chelsea Smith/Adam Hern
Registrant:	Present, not represented but accompanied by her mother and aunt at the adjourned hearing; Registrant did not attend the resumed hearing and was not represented.
General Pharmaceutical Council:	Represented by Deborah Tompkinson, counsel
Facts proved:	All
Facts proved by admission:	None
Facts not proved:	None
Fitness to practise:	Impaired
Outcome:	Removal
Interim measures:	Suspension

This decision including any finding of facts, impairment and sanction is an appealable decision under *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010*. Therefore, this decision will not take effect until 2 July 2024 or, if an appeal is lodged, once that appeal has been concluded. However, the interim suspension set out in the decision takes effect immediately and will lapse when the decision takes effect or once any appeal is concluded.

Particulars of Allegation (as amended)

You, a registered pharmacist technician (Registration no. 5101512) whilst employed as an Accuracy Checking Technician with Boots, Lowestoft:

1. Falsified the initials of a pharmacist, Witness B:
    1.1. on up to four prescriptions dated 21 April 2021 **[PROVED]**
    1.2. on up to two prescriptions dated 23 April 2021 **[PROVED]**
    1.3. on up to three prescriptions dated 26 April 2021 **[PROVED]**
    1.4. on up to five prescriptions dated 27 April 2021 **[PROVED]**

2. In respect of the prescriptions at 1 above, you failed to ensure that the relevant prescriptions had been clinically checked by the appropriate pharmacist. **[PROVED]**

3. Falsified the initials of a pharmacist, Witness A
    3.1. on up to two prescriptions dated 23 March 2021 **[PROVED]**
    3.2. on up to four prescriptions dated 14 April 2021 **[PROVED]**
    3.3. on up to five prescriptions dated 20 April 2021 **[PROVED]**

4. In respect of the prescriptions at 3 above, you failed to ensure that the relevant prescriptions had been clinically checked by the appropriate pharmacist. **[PROVED]**

5. Your actions at 1 and/or 2 and/or 3 and/or 4 above were dishonest and/or lacking in integrity in that;
    5.1. You were aware that the prescriptions had not been clinically checked when you falsified the signatures of Witness B and/or Witness A **[PROVED]**
    5.2. You intended to give the impression that the prescriptions had been clinically checked by a pharmacist. **[PROVED]**

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

Documentation

Document 1 - GPhC hearing bundle produced at the outset of the hearing

Document 2 - GPhC skeleton argument

Document 3 - GPhC Document showing correlation of particulars of allegation to evidence in bundle.

Document 4 – updated GPhC hearing bundle prepared for the resumed hearing, including additional documents provided by the Registrant

Document 5 – Proof of Service bundle prepared for the resumed hearing

Document 6 – Proceeding in Absence bundle prepared for the resumed hearing

Witnesses

Witness A, Pharmacist, Boots, Lowestoft – gave oral evidence at facts stage

Witness B, Pharmacist, Boots, Lowestoft, at the material times - gave oral evidence at facts stage

Witness C, Pharmacy Assistant Dispenser, Boots, Lowestoft - gave oral evidence at facts stage

Witness D, Store Manager, Boots, Lowestoft, at the material times - gave oral evidence at facts stage

The Registrant did not give oral evidence.

Determination

Introduction

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

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

3. The statutory overarching objectives for these regulatory proceedings are:

   a. To protect, promote and maintain the health, safety and well-being of the public;

   b. To promote and maintain public confidence in the professions regulated by the Council; and

   c. To promote and maintain proper professional standards and conduct for members of those professions.

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

5. A Principal Hearing has up to three stages:

   Stage 1. Findings of Fact – the Committee determines any disputed facts.

   Stage 2. Findings of ground(s) of impairment and impairment – the Committee determines whether, on the facts as proved, a statutory ground for impairment is established and, if so, whether the Registrant's fitness to practise is currently impaired.

   Stage 3. Sanction – the Committee considers what, if any, sanction should be applied if the Registrant's fitness to practise is found to be impaired.

Service of Notice of Hearing

6. The Committee has seen a letter dated 7 November 2023 from the Council headed 'Notice of Hearing' addressed to the Registrant. The Committee was satisfied that there had been good service of the Notice in accordance with Rules 3 and 16.

Application to amend the particulars of allegation

7. Prior to the start of the hearing the Committee heard an application by Ms Tompkinson under Rule 41 to amend particulars 1, 1.4, 5, and 5.1 as follows:

    1. In paragraph 1, the spelling of the Pharmacist's name to be corrected to "Larter" from "Later".
    2. In paragraph 1.4 the number of prescriptions to be amended from "six" to "five".
    3. Paragraph 5 to be amended from "Your actions at 2 and/or 3 above were dishonest and/or lacking integrity in that …" to "Your actions at 1 and/or 2 and/or 3 and/or 4 above were dishonest and/or lacking in integrity in that …"
    4. In paragraph 5.1, the spelling of the Pharmacist's name to be corrected to "Larter" from "Later".

8. The application was made on the grounds that these amendments were required to correct spelling errors and to reflect the evidence on which the Council relied. The Registrant told the Committee she did not oppose these proposed amendments.

9. The Committee was of the view that the proposed amendments reflected the documentary evidence before the Committee. There was no prejudice to the Registrant in making the amendments. Indeed, insofar as the proposed amendment at paragraph 1.4 was concerned, this was to her benefit. Amendment of the particulars of allegation, as proposed was consistent with the overriding objective of these proceedings.

10. In the course of its discussion at the facts stage, the Committee identified that if less than the full number of prescriptions at Particulars 1 and 3 were found to have been falsified, it could not go on to consider whether the Registrant had falsified the prescriptions in that Particular. The Committee, of its own motion, pursuant to Rule 41(1), invited the parties to make representations on whether those Particulars should be amended to add the words "up to" before the number of prescriptions. Ms Tompkinson agreed that it was in the public interest for such amendments to be made. The Registrant said she had no objection; she would not have prepared her case differently if the amendment had been made earlier. The Committee decided it was in the public interest for these amendments to be made and did so accordingly. The Committee invited the parties to make supplementary submissions on facts if they wished to do so. The Registrant made a short statement by way of submission.

Application for the hearing to be held in Private

11. Ms Tompkinson noted a number of references in the bundle to the Registrant's health. It was not proposed to make an application, at the outset of the hearing, for parts of the hearing to be held in private, pursuant to Rule 39(3) but if such references occurred in the course of the hearing, an appropriate application might be made at that time. The Registrant agreed with this approach, as did the Committee.

Registrant's response to Particulars of allegation

12. The Registrant denied the particulars in their entirety.

13. The Committee went on to receive evidence and submissions regarding all the particulars of allegation.

Background

14. The Registrant was employed by Boots UK Limited ("Boots") between 9 November 2009 and 13 August 2021. At material times she was employed as an Accuracy Checking Technician ("ACT") at Boots' Lowestoft branch. She worked primarily in the "dosette box" room and was responsible for ensuring the dosette boxes were accuracy checked and generally ensuring efficiency in the process. Occasionally the Registrant would also work in the "care homes room" and the walk-in pharmacy.

15. Dosette boxes are a support tool for people who struggle with taking tablets. It is a plastic tray in which a patient's medicine are retained in separate compartments. The box identifies the medicine which should be taken at specific times of the day, on each day of the week. Each box contains a week's worth of medication; it has clear labels with times and days to remind a patient to take their medication correctly.

16. By letter dated 23 December 2021 the Council was notified by the Chief Pharmacist's Office of Boots UK Limited ("Boots") of concerns about the pharmacy practice of the Registrant, who worked in its London Road, Lowestoft, Pharmacy ("the Pharmacy"). Boots notified that

> "upon investigation, several prescriptions appeared to have been initialled by [the Registrant] indicating that a pharmacist had performed a clinical check. It was determined, however, that [the Registrant] had falsified the pharmacist's initials without their knowledge or consent. During the disciplinary interview, [the Registrant] could not offer a reasonable explanation for not following the Company's standard operating procedures and thus potentially putting patients at risk. [The Registrant] was subsequently dismissed on 13 August 2021."

17. The Council was provided by Boots with records of its disciplinary investigation. The investigation was initiated when OS, the store manager at Boots, Lowestoft, was notified by his assistant manager that two dispensers, RN and AT, had raised concerns that they had been asking the Registrant to get prescriptions clinically checked; the prescriptions were being marked as clinically checked without the Registrant taking them to the pharmacist. The assistant manager notified OS that this had been a concern for the two dispensers since September 2019. The dispensers had initially spoken to the Registrant about their concerns and she had reassured them that the pharmacist had told her she was allowed to accuracy check the box before it was clinically checked and that she should take it to the pharmacist

afterwards. They felt reassured, at the time, by her explanation notwithstanding this was not the usual procedure which required clinical checks before accuracy checks.

18. Having been notified of these concerns, OS spoke to RN and AT who reiterated their initial concerns. OS found several prescriptions which had been signed off with "W" or "H" for LS and HL (both pharmacists) respectively. As part of his investigation, OS spoke to LS and HL who both advised him that the initials on the prescriptions were different to the stamps they used. OS checked the stamps for himself and considered that the signatures on the prescriptions were indeed different.

19. On 11 May 2021, on her return from holiday, OS spoke to the Registrant. He asked her about the checking procedures and the correct way to complete these. He then asked whether the Registrant had clinically checked prescriptions. Initially she said she had not and that she never would. OS then told the Registrant that some prescriptions had been signed under his name, showed her the prescriptions concerned and informed her that he did not have the authority to clinically check prescriptions. According to the interview record, the Registrant continued to deny having signed the prescriptions. While OS was on the telephone, seeking advice from Boots' head office, the Registrant came into his office and admitted she had clinically checked the prescriptions using a dispensing stamp that looked similar to that of OS (which looks like the number "1"). She told OS she had marked the prescriptions with a "J", which was different to her usual mark, to remind herself to get the prescriptions clinically checked by the pharmacist later because she had not had time to do this before doing her accuracy check.

20. A disciplinary interview took place with the Registrant on 3 June 2021. At that meeting the Registrant said she "made a misjudgement on two days where [she] did not follow protocol. [She] followed the pharmacist recommendations verbally to check some DDS [dosette boxes] which had not be [sic] CC'd [clinically checked]." She said she regretted what she did and accepted she should have followed procedures; she acted out of ignorance; she had spoken to the pharmacist and did what they said." The Registrant said she was aware that what she had done was wrong; she had been under pressure at work. She reported that she had had the "verbal agreement" of HL to sign off for clinical checks and that she, the Registrant, had been overworked and lacked support.

21. At a disciplinary meeting on 20 July 2021 the Registrant was told that she had "gone on record to say [she] had signed the clinical checking box on prescriptions". The Registrant responded that she

> "had a verbal agreement with [HL] to do so if nothing had changed as we were so far behind, she was happy for me to do this, then to take them to her at a later date to be clinically checked. I was following what I was told by someone above me. I understand that it goes against SOPs, that I shouldn't have done it. I've not done it before. It was for two days, I was doing the DDS, the quantity to be done was immense. …"

The Registrant accepted in that meeting that she had put a "J" in the CC box on the two days when she had spoken to HL.

22. The Registrant was employed as an Accuracy Checking Technician. She did not have authority to clinically check prescriptions. This task was limited to a registered pharmacist.

23. The Registrant has a number of health issues.

Decision on Facts

24. In reaching its decisions on facts, the Committee considered the documentation listed at the start of this determination, the oral evidence and the submissions made by the GPhC and the Registrant. The Registrant elected not to give oral evidence at this stage.

25. 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.

26. Given that the allegations include, in this case, allegations of dishonesty and lack of integrity, the Committee has given anxious scrutiny to the evidence in reaching its conclusions on the facts.

Particular 1

The Committee first considered whether the initials on each of the prescriptions concerned were falsified before considering whether they were falsified by the Registrant.

Ms Tompkinson identified each of the relevant prescriptions with a number, corresponding to the sub-paragraph at issue, to assist the Committee and the Registrant. The Committee has used that nomenclature to identify each prescription in this determination.

<u>Prescription 1.1.a</u>
Witness B told the Committee that on a scale of 1 to 10, there was zero likelihood that the "H" on this prescription was hers. She said the "loops are in a different place"; also the markings down the side of the prescription were in a different place and she tended to make a marking closer to the drug name, higher up than was the case on this prescription.

The Committee was satisfied, on the evidence of this witness that her signature on prescription 1.1.a had been falsified.

Prescription 1.1.b
Witness B's oral evidence is that there was zero likelihood that the "H" was hers. On this evidence, the Committee finds it was falsified.

Prescription 1.1.c
Witness B's oral evidence is that she was certain this was not her signature; she said it did not look like an "H". she said there was a zero likelihood this was her signature. The Committee finds this prescription was falsified.

Prescription 1.1.d
Witness B's oral evidence is that there was zero likelihood of this being her signature because the loop on the "H" was in the wrong place. The Committee finds this prescription has been falsified.

Prescription 1.2.a
Witness B told the Committee this signature looked a "bit more like mine, maybe a 2" on a likelihood scale of 1 to 10. However, she said that, having looked at her genuine signatures on other prescriptions, where she had both accuracy and clinically checked she believed that these signatures on this prescription were not hers. The Committee finds this prescription has been falsified.

Prescription 1.2.b
Witness B told the Committee that there was zero likelihood that this was her signature because the loops were at the bottom of the H rather than the top as would be the case with her signature. The Committee finds this prescription has been falsified.

Prescription 1.3.a
Witness B's oral evidence is that she is "pretty sure this is not mine, a 2" on a likelihood scale of 1-10. She concluded this because the prescription had been marked on the side with a tick and if she had ticked the prescription it would not have been that kind of tick. She noted that the H was not that visible on the copy in the bundle and she could not be 100% certain but she had thought it was a 2 out of 10 because the prescription did not show her normal markings next to the prescription item. The Committee finds this prescription has been falsified.

Prescription 1.3.b
Witness B gave this a score of zero on the scale of likelihood of its being her signature. Her reason was that this did not look like her "H"; she would "do it all in one go"; she believed it looked as though the H had been done "separately". She said there was zero likelihood that the tick on the prescription had been done by her. She did not tick like that; she would have done it next to the item and in an upward direction. The Committee finds this prescription has been falsified.

Prescription 1.3.c
Witness B assessed the likelihood of this being her signature as zero because the H had a loop at the bottom left. She also said the ticks were not of the type she used. The Committee finds this prescription has been falsified.

Prescription 1.4.a
It is Witness B's evidence that there is zero likelihood of this being her signature because the letter did not really resemble an H and the loop was in the wrong place. Furthermore, the ticks on the prescription did not look like hers. The Committee finds this prescription has been falsified.

Prescription 1.4.b
Witness B's evidence is that there was zero likelihood of this being her signature because although there was a loop on the top right of the H, there was also one bottom left which she did not tend to do on her signature. Also the ticks on the prescription were not the same as hers and not quite in the right place. The Committee finds this prescription has been falsified.

Prescription 1.4.c
Witness B's evidence is that there was a zero likelihood of this being her signature because the loops on the H were in the wrong place. In addition, the ticks on the page were too low down to be hers. The Committee finds this prescription has been falsified.

Prescription 1.4.d
Witness B's evidence is that there was a zero likelihood of this being her signature because the loop on the H was on the bottom left-hand corner as opposed to the top right which was how she signed. Furthermore, the ticks were not hers; they were not quite in the right place. The Committee finds this prescription has been falsified.

Prescription 1.4.e
Again Witness B told the Committee that there was zero likelihood of this being her signature because the loop was not in the right place; it was on the bottom left of the H and she did not do that. Also the ticks were not in the right place. The Committee finds this prescription has been falsified.

On the issue of whether the Registrant falsified these prescriptions, the Committee has had regard to her assertion (albeit not made on oath in oral evidence) that she has never falsified a pharmacist's signature. This assertion was made during the Boots disciplinary investigation and during her submissions.

There is no direct evidence that the Registrant forged the signatures of the two pharmacists. The Committee has ignored the speculation of the Registrant's colleagues that she was responsible for the forgeries. It has carefully considered the weight and cogency of the evidence against the backdrop that it is improbable that a member of the pharmacy profession would falsify prescriptions. Pharmacy technicians are required to adhere to professional standards which include honesty and integrity.

All the falsified prescriptions were either accuracy checked by the Registrant or included a false signature in the accuracy check box. There is no evidence of the other ACT in Boots, LW, having accuracy checked the prescriptions and, in any event, she worked in the care homes room, only working in the dosette box room when needed. At the material times, the

Registrant was working in the dosette box room and there would have been no need for LW to work there. It is highly unlikely that LW falsified the prescriptions.

The Committee could identify no conceivable motive for the three dispensers to forge the initials of the pharmacists.

The Committee has considered the Registrant's working environment. She had returned to work from extended rehabilitation. The Registrant said in interview with OS that she had been working under pressure, that she felt ignored and that when she had asked for help it had not been forthcoming. In contrast AT, the dispenser, told the Committee the dosette room was running smoothly. This was confirmed by OS. Thus there is a discrepancy in the evidence as regards the efficiency of the dosette room for which the Registrant was responsible. AT told the Committee there was never any difficulty getting prescriptions clinically checked. She was the person from the dosette room who usually asked pharmacists to clinical check prescriptions.

Both LS and HL, the pharmacists, assumed that each other or another pharmacist had been doing clinical checks because they had not been asked themselves to do them. In her interview with OS, LS said she realised she "had not clinically checked a weekly dosette box in months". She had assumed that HL had checked the weekly dosette boxes on Tuesdays. Her evidence is that "as a pharmacist you only clinically check what is brought to you." LS' oral evidence was consistent with this: she could not remember doing dosette boxes for "quite some time" partly because she was off work and only working 3 days a week. She said it was not unusual that she did not clinically check for a "few weeks".

The Registrant said in interview that she had followed HL's recommendation to check some DDS which had not been clinically checked. However, HL denied in oral evidence having any such agreement with the Registrant. AT's evidence is that she was told by the Registrant that HL had allowed the Registrant to sign for her but when AT asked HL about this HL denied it, saying she had not spoken to the Registrant in such terms. Thus there is a significant discrepancy in the evidence about the Registrant's checks of prescriptions.

The Registrant said in interview she needed regular breaks due to fatigue and that there was no support for her to take those breaks when she needed to. She said "on at least two occasions I started at 8.30am and would get a break @ 3pm – but even then I would be told, this needs to be checked it's on delivery". This suggests she felt under pressure in her work.

AT's evidence is that Kate, a pharmacist who had previously worked in the branch, had agreed with AT and the Registrant she was happy for her to check the weekly dosettes and sign her initials in the CC box, subject to any changes or concerns being left with the pharmacist. According to AT, she was the only pharmacist who allowed this, meaning it was only acceptable when she, the pharmacist, was signed on. The Committee considers it notable that this account is consistent with the allegation that the Registrant signed the CC box. AT denied having done so.

The Registrant initially told OS in the investigatory interview on 11 May 2021 that she followed due process the "majority of the time" unless the process "gets interrupted". She

was asked at that interview whether she had at any point ever not followed the SOP regarding clinical checking. In reply she cited one example of such a situation. She was asked whether that was the only occasion in the last year when something had been checked without "CC". The Registrant responded that she did not want to get people in trouble but that there had been checking without CC. The Registrant was asked whether she had ever signed in a CC box on behalf of someone else and replied "100% no"; she had never signed a "CC" box except on a reprint or if she had accidentally signed the incorrect box. The Registrant has not elaborated in these proceedings on her earlier suggestion that there had been checking without CC.

When the Registrant was initially shown, in her disciplinary interview, a number of prescriptions with a line in the CC box (resembling the signature of OS), the Registrant did not initially disclose she had put the mark in the box. This is despite being told by OS that it looked like his signature. If, as the Registrant later admitted, she had signed the box herself, it could be expected that she would admit this at the first opportunity; she would recognise her own handwriting. It was only after a break in the interview that the Registrant said she had signed those prescriptions herself and that the mark was a "J" rather than a line resembling OS' signature. However, the marks on those prescriptions do not appear to the Committee to be a "J". There is no explanation for the late disclosure of the Registrant's marking the CC box in this way.

The Registrant has a number of health issues but there is no suggestion in the documentary evidence that this has had a detrimental impact, at material times, on her judgment and decision-making.

The Registrant admitted in interview that she breached the SOP regarding clinical checks. During her cross-examination of the Council's witnesses, she sought to suggest that other members of staff breached SOPs also. Her evidence and line of questioning suggest she perceived breaches of SOPs to be endemic.

OS' oral evidence is that after May 2021 and until he left Boots in Lowestoft earlier this year there were no other issues with falsified signatures on prescriptions. He also said that he had been told by staff that problems with signatures had dated back to September 2019; he accepted the Registrant was not working at the store at that time. Furthermore, AT (who is alleged to have passed this date to OS) denied she had given this date to OS; she asserted that his reference to that date in his statement was an error (as indeed OS accepted in oral evidence).

The Registrant's witness statement appears to have been drafted for employment tribunal proceedings; it has little bearing on the allegations that she falsified prescriptions.

Thus there are some discrepancies as between the evidence of the Council's witnesses and the records of the Registrant's interview during the disciplinary process. In particular the picture painted by the Registrant of the workload in the dosette room is not mirrored in the evidence of the Boots' employees called for the Council.

The Committee has considered whether other staff members at Boots might have been involved in the falsification of signatures but the evidence does not point to a motive for such deception: AT, the dispenser, said that there were no issues with working in the dosette room. She had no motive to speed up the clinical checks. By contrast, the Registrant considered herself to be under pressure in that room and she would have had a motive to accelerate the process to ensure the prescriptions were dispensed and handed out. She was in overall control of the room. She was also the last person in the dispensing process to deal with the prescriptions before they were passed to the patient so she would have felt the pressure of meeting the delivery deadline. The dosette room is a long narrow room where AT and the Registrant were shielded from each other by a computer. The Registrant would therefore have had the opportunity to falsify prescriptions clandestinely.

The Committee has scrutinised the evidence carefully. It has concluded that the Registrant's accounts in the various interview records are not wholly consistent, either internally or with other members of staff. By way of example, she initially said in interview that she followed due process 100% of the time but backtracked later in interview admitting she had not followed SOPs. This suggests her evidence in the disciplinary interviews was evasive and not wholly truthful.

The Committee has had regard to the seriousness of the allegations and the inherent improbability of a member of the pharmacy profession falsifying various prescriptions with the false signatures of two pharmacists. However, there are various instances of the Registrant not acting in compliance with good practice, professional standards and the SOPs with regard to checking prescriptions: in particular by allegedly adding a mark to a CC box. This is an illogical method of highlighting to a pharmacist that a clinical check needs to be done (as the Registrant contends). While this is not an allegation against her, she has raised it in these proceedings and her explanation for putting a letter "J" in a CC box is improbable.

The Committee has borne in mind that the more serious the allegation, the less likely it is to have occurred. Strong evidence is required for a finding of dishonesty and/or lack of integrity. The Committee has weighed the probabilities and concluded that it is more likely than not that the Registrant falsified the signatures on the prescriptions, as set out above.

In summary,

Particular 1

1. Falsified the initials of a pharmacist, Witness B:

1.1. On up to four prescriptions dated 21 April 2021.

1.2. on up to two prescriptions dated 23 April 2021

1.3. on up to three prescriptions dated 26 April 2021

1.4. on up to five prescriptions dated 27 April 2021

This particular is found proved in its entirety.

Particular 2

2. In respect of the prescriptions at 1 above, you failed to ensure that the relevant prescriptions had been clinically checked by the appropriate pharmacist.

All the prescriptions should have been clinically checked in accordance with the SOP. It follows that, the Registrant having falsified the signature of HL, failed to ensure the prescriptions were clinically checked by a pharmacist.

This particular is found proved.

Particular 3

1. Falsified the initials of a pharmacist, Witness A

The Committee has used the nomenclature imposed by Ms Tompkinson to identify each of the prescriptions in the sub-paragraphs of this Particular, and has considered as a preliminary issue whether each of them has been falsified.

Prescription 3.1.a

On this prescription there are two "W" signatures on the AC and CC boxes. Witness A was asked how usual it was for her to check both boxes and she replied that it depended on the workload. It was common that she would do so. She was unable initially to confirm it was her signature. She noted the prescription was dated 23 March 2021 and expected that the patient would receive the prescription before 30 March 2021, probably on 25 March 2021. There was no date of signature on the prescription. Witness A said she was on furlough in March 2021, ending on 31 March 2021. She said the weekly prescriptions were usually signed off within six days. While Witness A could not be sure, she initially thought the signatures were hers then realised that there were not her customary two marks on the prescription; she normally did two marks to check the items and scored through the first mark when she checked it into the box. She noted that this prescription did not have a second "score through" which was "out of practice" for her. She said that normally her prescriptions had pen all over them. In conclusion Witness A said that the CC was "unlikely because of the date of the prescription". The likelihood it was her signature was "low". She was not in store at the material time and the marks were not consistent with her usual practice. The Committee finds this prescription has been falsified.

Prescription 3.1.b

Witness A told the Committee that her evidence on this one was similar to that relating to prescription 3.1.a which had the same date. She said it was unlikely she "clinicalled" this one. She said it was not likely to be her signature in the box although it looked like it. She was not in store for another ten days after the date of the prescription. The Committee finds this prescription has been falsified

Prescription 3.2.a

Witness A said she was not working on the date of this prescription, 14 April 2021; she was off on 14, 17 and 18 April. But she could not guarantee the date of the clinical check. She said she was in store on 16 April 2021 so there was "quite a likelihood" she could have "clinicalled" it two days after it was printed. She agreed that the prescription did not have the check strike to which she had referred earlier as being her usual route. But she said it was impossible to say whether the signature was false. The Committee does not find this prescription has been falsified.

Prescription 3.2.b

On this prescription Witness A's concern was that the two signatures, both purportedly hers, Ws, had been linked together. She described the procedure for clinical checks as being that as soon as data was entered, the prescription would go back up to be dispensed and then would be accuracy checked. She said that even if she had clinically checked and accuracy checked these checks were not normally done at the same time; there would be a gap. The Ws would not have been linked as they were on this prescription. She said sometimes, CCs and ACs were done at the same time but this was not normal practice. On the scale of likelihood that these were her signatures, Witness A said 2-3. The Committee finds this prescription has been falsified.

Prescription 3.2.c

Witness A noted there were no marks on this prescription at all and she said it was unlikely she clinically checked it. The likelihood was 2-3 on a scale of 1-10. The Committee finds this prescription has been falsified.

Prescription 3.2.d

Witness A said she did not feel confident she had clinically checked this prescription. She described the likelihood as being 2-3 on a scale of 1-10. She said she could not put her hand on her heart and say she didn't do it but she did not "believe I would have done that signature". The Committee finds this prescription has been falsified.

Prescription 3.3.a

Witness A described the likelihood of this being her signature as 4-5 on a scale of 1-10. The Committee has noted the double ticks on this prescription; these were not addressed in oral evidence by the witness. Given the witness's assessment and this missing evidence the Committee does not find this prescription was falsified.

Prescription 3.3.b

Witness A said, on a scale of 1-10, it was 4-5 likely that this was her signature. She was not asked about the double ticks on this prescription but her earlier evidence was that she would have used double ticks. The Committee does not find this prescription was falsified.

Prescription 3.3.c

There are linked Ws on this prescription which purport to demonstrate Witness A both accuracy checked and clinically checked the prescription at the same time. Witness A said, as she had in relation to another prescription, it was unlikely she would have ACd and CCd the

prescription at the same time. She could not be confident these were her signatures; she gave a likelihood of 3-4 that this was the case. The Committee finds this prescription has been falsified.

Prescription 3.3.d

Witness A said the likelihood of this being her signature was 5 out of 10. She noted the double ticks on the prescription. On this evidence the Committee does not find this prescription was falsified.

Prescription 3.3.e

Witness A gave no oral evidence on the issue of whether she considered the signature on this prescription to be genuine. In the absence of any specific evidence on this issue, the Committee does not find this prescription was falsified.

Insofar as the issue of whether the Registrant falsified the prescriptions is concerned, the Committee adopts its findings as set out above in relation to Particular 1. It concludes that the Registrant did so.

In summary,

3. Falsified the initials of a pharmacist, Witness A

3.1. on up to two prescriptions dated 23 March 2021

3.2. on up to four prescriptions dated 14 April 2021

3.3. on up to five prescriptions dated 20 April 2021

This particular is found proved.

Particular 4

4. In respect of the prescriptions at 3 above, you failed to ensure that the relevant prescriptions had been clinically checked by the appropriate pharmacist.

For the reasons set out above in relation to Particular 2, the Committee finds this particular has been proved.

This particular is found proved.

Particular 5

5. Your actions at 1 and/or 2 and/or 3 and/or 4 above were dishonest and/or lacking in integrity in that;

5.1. You were aware that the prescriptions had not been clinically checked when you falsified the signatures of Witness B and/or Witness A

5.2. You intended to give the impression that the prescriptions had been clinically checked by a pharmacist.

The Committee has had regard to the guidance in **Ivey v Genting [2017] UKSC 67** and the test reaffirmed by the Supreme Court in that case.

The Committee has found the Registrant falsified initials on various prescriptions and that she failed to ensure that they had been clinically checked by the appropriate pharmacist. She knew this was a breach of SOPs which required a pharmacist to undertake clinical checks of prescriptions. She knew what she was doing was wrong and a breach of professional standards. The Registrant seeks to suggest that others breached SOPs at Boots in Lowestoft but that is not the issue here. The Committee is in no doubt that ordinary people would consider the Registrant's actions to be dishonest and to lack integrity. The falsification of the prescriptions was for the purpose of avoiding a clinical check; the Registrant intended to give the impression, by falsifying the pharmacists' signatures, that the prescriptions had been clinically checked by a pharmacist.

This particular is found proved.

Misconduct and Impairment

Preliminary Issues

27. The hearing resumed on 3 June 2024 for the second stage, having been adjourned on 13 December 2023 for lack of time.

28. The Registrant did not attend the resumed hearing. She had initially indicated in email correspondence with the Committee Secretary in April 2024 that she would be able to attend on 3 June but in further email correspondence sent to the Council on 29 May 2024, she indicated that she would not attend. The Committee therefore considered as a preliminary issue, whether the notice of resumed hearing had been served on the Registrant and whether to proceed in her absence. For the Council, it was submitted by Ms Tompkinson that the notice had been properly served and that the hearing should proceed in the absence of the Registrant who had voluntarily absented herself.

29. On the issue of service, the notice of hearing was sent to the Registrant by email on 25 April 2024. It was sent to the email address which is entered on the Council's register. Rule 3 (as amended by *The General Pharmaceutical Council (Coronavirus) (Amendment) Rules 2021*) provides that "any notice or document required to be served by the Council under these Rules must be in writing and may be served by sending it by a postal service or another delivery service (including by electronic mail to an electronic mail address notified to the Registrar as an address for communications) …". Service of the notice of hearing is compliant with this provision and the Committee therefore determines that the notice of hearing has been validly served on the Registrant.

30. The Committee then turned to the issue of whether or not it should proceed with the resumed hearing in the absence of the Registrant. It has had regard to the provisions of Rule 25(b), the submissions for the Council and the Registrant's comments in her emails to the Council.

31. The Committee has borne in mind the guidance in **Adeogba v GMC [2016] EWCA Civ 162** on the exercise of discretion when deciding whether to proceed in the absence of a practitioner. In exercising that discretion (per paragraph 23 of **Adeogba**) "discretion must then be exercised having regard to all the circumstances of which the Panel is aware with fairness to the practitioner being a prime consideration but fairness to the GMC and the interests of the public also taken into account".

32. The Committee has also had regard to the guidance in **R v Jones [2003] 1 AC 1** to the effect that the exercise of its discretion is severely constrained.

33. The Committee has been provided with a screenshot demonstrating that the email sent to the Registrant and containing the notice of hearing was accessed by "Barbara Collins (barbs1203@aol.com)" on 25 April 2025 at 7.28 pm. The Committee is aware from the earlier hearing that Barbara Collins is the Registrant's mother; she accompanied the Registrant at the earlier, adjourned, hearing. On 29 May 2024 at 2100 hrs the following email was sent to the Committee Secretary:

> "… One of the continual issues that we have had with the GPHC hearing is the prolonged delays that have set the hearing back further and further.
>
> Boots have now offered a financial settlement to Jennie via their solicitors, and she has have [sic] accepted. This does however mean that we are now restricted in the information we can disclose.
>
> As every member of the staff concerned in this hearing has now either left, or been asked to leave, we see no benefit in continuing this process as it no longer has any bearing on the truth. This means that the GPHC has lost the opportunity to deliver its standards and make pharmacies a safer place.
>
> We have presented all of the evidence namely Jennie was never accused of falsifying prescriptions, never worked full time in fact only working 1-2 days in

the DDS room and wasn't even employed in Boots Lowestoft when the issue started.

We therefore feel that there is no benefit in continuing.

We would request no further correspondence from yourselves or your organisation.

Kind regards

Barbara Collins
Jennie Collins
Paul Collins"

34. The Committee is satisfied that the Registrant is aware of this hearing. The Registrant is also aware from the Committee's determination on facts of the issues to be decided.

35. The Registrant attended the adjourned hearing in December 2023 with her mother and her aunt. She was not legally represented. The Committee infers that she would not have legal representation at this resumed hearing either.

36. The Committee does not consider there is merit to an adjournment of this hearing given the Registrant's view that there is no benefit to her in attending. She has clearly disengaged from these proceedings. The Committee is unable to draw an inference that the Registrant would attend a future hearing if this hearing were adjourned. She appears, from the information before the Committee, to have voluntarily waived her right to be present knowing that her fitness to practise as a pharmacy technician is to be decided by this Committee.

37. The Committee balanced the public interest in proceeding with this matter expeditiously against the interests of the Registrant in attending the hearing and putting her side of the case. It noted that the Registrant did not give oral evidence at the facts stage which suggests, in combination with the comments in the email cited above, that she would not choose to do so at later stages of the hearing. The Committee concluded that it was in the public interest, including for the protection of patients, that this resumed hearing proceed in the absence of the Registrant.

38. In making its decision whether to proceed in the absence of the Registrant, the Committee recognised that, if it were to proceed, the Committee would be obliged to ensure the hearing was as fair as possible to both parties, notwithstanding the absence of the Registrant or any representation for her. It would be obliged to expose any weaknesses in the Council's case and to make points on behalf of the absent Registrant as the information before it permitted.

39. The Committee therefore proceeded with the resumed hearing in the absence of the Registrant. In so doing it takes into account the additional evidence of the Registrant.

40. Having decided to proceed, the Committee noted the additional documentation provided by the Registrant for this stage of the hearing. In particular the Committee noted the document headed "Application to amend the particulars of allegation". This document consists of various comments, by reference to exhibits, on the content of the Committee's determination on facts. It does not cite specific proposed amendments to the particulars of allegation. The Committee decided therefore that this was not in fact an application to amend but was a document created to ensure the Committee was aware, at this stage of the hearing, of the Registrant's comments on the facts found proved.

41. By way of further preliminary issue, the Committee also considered those comments of the Registrant on the Committee's findings of fact. Those comments are set out in detail and also summarised in the email cited above in that the Registrant asserts she "was never accused of falsifying prescriptions, never worked full time in fact only working 1-2 days in the DDS room and wasn't even employed in Boots Lowestoft when the issue started". While the Committee has considered carefully the detailed comments of the Registrant, it makes the following observations: the reference to the Registrant working "full-time" is set out in the background to the particulars of allegation; it is not a finding of fact. Nonetheless, the Committee accepts that the Registrant was working 30 hours per week and that this may not be considered as full-time work. With the agreement of Ms Tompkinson, for the Council, the Committee has deleted "full-time" from the background to the hearing at paragraph 14 of the determination on facts. The Committee agrees with the Registrant that there are inconsistencies in the evidence of the witnesses, including as regards the timing of these events and the workload generally, but considers that the reasons for its findings of fact (which are limited to the period of the particulars of allegation) are sufficiently explained. The Committee is satisfied that, notwithstanding the comments of the Registrant, its findings are grounded in the evidence before the Committee, including that adduced by the Registrant for this stage of the hearing. In summary, and to be clear, the Committee does not derogate from its findings of fact notwithstanding the comments of the Registrant as produced at this stage of the hearing. Furthermore, the Committee notes the Registrant's comments in an email dated 1 April 2024 to the Council's lawyer, as follows:

> "It is not the expectation of Ms Collins that the case would be re-opened at this stage, however, it was felt that as the decision has been taken 'upon the facts' with a 'balance of probabilities' that those facts should be accurate. Therefore we would request that the documents be added to the bundle so they can be considered by the committee when they resume the hearing to determine whether the 'proved conduct' amounts to 'misconduct'.
> …
> It would be appreciated if the committee would simply consider the information and facts presently being added to the bundle as part of their determination.
>
> Please incorporate this email by way of explanation to the committee."

42. The Registrant can be assured that, notwithstanding her absence at this stage of the hearing, the Committee has taken, and will take, into account her additional comments in reaching its decision on misconduct and fitness to practise (and that it will do so if further stages are reached in these proceedings).

43. Ms Tompkinson applied, in the absence of the Registrant, for consideration by the Committee as to whether the hearing should be held in public and/or in private, given earlier references to the Registrant's health. The Committee decided that the hearing should be held in public but if there were references to the Registrant's physical or mental health, those matters should be addressed in private pursuant to Rule 39(3).

Decisions on Misconduct and Impairment

44. Having found at the previous hearing that all the particulars of allegation were proved, the Committee went on to consider whether the particulars found proved amounted to misconduct and, if so, whether the Registrant's fitness to practise is currently impaired.

45. The Committee took account of the guidance given to the meaning of 'fitness to practise' in the Council's publication *"Good decision-making: Fitness to practise hearings and outcomes guidance"* (Revised March 2024). 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 or pharmacy technician safely and effectively. In practical terms, this means maintaining appropriate standards of competence, demonstrating good character, and also keeping to the principles of good practice set out in our various standards, guidance and advice."*

46. The Committee took into account the submissions made by Ms Tompkinson. The Committee has had regard to the documentary evidence of the parties, as included in the Council's bundle. It has not heard oral evidence at this stage of the proceedings.

47. Ms Tompkinson submitted that the Registrant had breached Standards 6, 8 and 9 of the Standards for Pharmacy Professionals issued in 2017 and that her conduct amounted to misconduct. She further submitted that Rule 5(2)(a)-(d) were engaged and that the Registrant's fitness to practise was impaired. Ms Tompkinson very fairly, in the absence of the Registrant, referred the Committee to those aspects of the Registrant's evidence which might support her position in these proceedings. She included references to the comments and documents produced by the Registrant at this stage of the proceedings.

48. The Committee has inferred that the Registrant disputes her actions amount to misconduct or that her fitness to practise is currently impaired.

Decision on misconduct

49. When considering whether the particulars found proved amounted to misconduct the Committee took into account the Council's guidance, as cited above.

50. The Committee considered whether the Registrant had breached any of the Council's Standards for Pharmacy Professionals (May 2017). The Committee determined that there had been breaches of the following Standards:

a. Standard 2 – Pharmacy professionals must work in partnership with others.
The Registrant did not work appropriately with the rest of the team within the pharmacy. It was a core task to undertake clinical checks. Her conduct undermined the safety and effectiveness of the provision to patients, including vulnerable patients. The Registrant did not engage with pharmacy colleagues in a professional manner. She failed to work with others to ensure continuity of care for patients. Patients using dosette boxes were particularly vulnerable and her actions could have caused them harm.

b. Standard 5 – Pharmacy professionals must use their professional judgement.
The Registrant, by her conduct and behaviour, failed to make the care of the patients her first concern; nor did she act in their best interests.
Pharmacy professionals must make the care of the person their first concern and act in their best interests. The Registrant took short cuts to achieve her own objectives, rather than complying with the SOPs which had been created to ensure safe pharmacy practice.

c. Standard 6 – Pharmacy professionals must behave in a professional manner.
The Registrant was dishonest in her dealings with professional colleagues, falsifying the initials of pharmacists who trusted her to work in accordance with best practice. She abused their trust. She abused the trust of her employer also. She was not trustworthy; she failed to act with honesty and integrity in the course of her pharmacy practice.

d. Standard 9 – Pharmacy professionals must demonstrate leadership.
The Registrant failed to take responsibility for her practice and to demonstrate leadership to the people she worked with. She failed to assess the risks associated with her conduct and behaviour.

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

52. In **Nandi v General Medical Council [2004] EWHC 2317 (Admin)** the court described misconduct as 'deplorable' conduct:

> "What amounts to professional misconduct has been considered by the Privy Council in a number of cases. I suppose perhaps the most recent observation is that of Lord Clyde in Rylands v General Medical Council [1999] Lloyd's Rep Med 139 at 149, where he described it as "a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be serious". The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners." (Per Mr Justice Collins, October 2004)

53. In **Shaw v General Osteopathic Council [2015] EWHC 2721 (Admin)**, Kerr J indicated how the issue of unacceptable professional conduct should be approached. At paragraph 47 he said:

> "It seems to me that Irwin J was, with respect, correct to observe that a charge of unacceptable professional conduct does entail conduct that, to some degree, is morally blameworthy and would convey a degree of opprobrium to the ordinary intelligent citizen."

54. The Committee has also noted the more recent guidance in **Khan v Bar Standards Board [2018] EWHC 2184 (Admin)** which identifies misconduct as conduct which is "seriously reprehensible".

55. The Committee has taken into account the circumstances of the Registrant's conduct, including her dishonesty.

56. The Committee has had regard to the comments of the Registrant on the Committee's determination on facts. The fact the Registrant was not working full time at the material time has no bearing on the potential issue of misconduct; irrespective of her working hours, it is not disputed she was acting in her professional role as a pharmacy technician. She should have adhered to the standards required of her profession at all times, irrespective of her working hours.

57. This Committee is concerned only with the facts found proved, not any other issues which might or might not have been addressed in the course of the disciplinary investigation and process conducted by Boots. As is clear from the findings of fact, the period of the dishonest conduct is relatively short in that the prescriptions were dated between 23 March 2021 and 27 April 2021 (although the precise dates of the dishonest acts are not known). The Registrant alleges other members of staff did not adhere to SOPs but this does not justify her actions: as a registered pharmacy professional she knew, or ought to have known, she was required to adhere to the standards of the profession.

58. The Committee is in no doubt that the falsification of a pharmacist's initials on various prescriptions in the context of failing to ensure the relevant prescriptions had been clinically checked by the appropriate pharmacist is a very serious matter indeed. It strikes at the heart of safe pharmacy practice. It cannot be condoned, however busy the practice (as is asserted by the Registrant in correspondence).

59. Fellow registrants and members of the public would consider the conduct of the Registrant to be seriously reprehensible and indeed shocking. While the Committee has had regard to the comments of the Registrant on the determination on facts, there can be no justification for her actions.

60. Accordingly, the Committee concluded that, in its judgment, the ground of misconduct is established.

Decision on Impairment

61. Having found that the facts amounted to misconduct, the Committee went on to consider, pursuant to Rule 5(2), whether the Registrant's fitness to practise is currently impaired. In doing so the Committee considered whether the particulars found proved show that the acts and/or omissions of the Registrant:

- *present an actual or potential risk to patients or to the public*
- *has brought, or might bring, the profession of pharmacy into disrepute*
- *has breached one of the fundamental principles of the profession of pharmacy*
- *means that the integrity of the Registrant can no longer be relied upon*

62. The Registrant has continued to deny dishonesty. Implicitly it is asserted that her conduct does not amount to misconduct. She has not demonstrated remorse or regret for her actions. The Registrant blames the Council for having failed to conduct an appropriate investigation into these matters. She has not participated in this hearing fully in that she has not given oral evidence at the facts stage; she has not participated at this stage.

63. Dishonesty is a character trait and difficult to remediate; that said, the Committee accepts that the falsification of records and failure to adhere to SOPs is capable of remediation.

64. However, irrespective of whether the Registrant's dishonest conduct is capable of remediation, the Committee has no option in the circumstances of this case but to conclude that the Registrant has not remediated her misconduct. She has demonstrated very limited insight into the impact of her actions on the protection of public and patients and the wider public interest, particularly the maintenance of professional standards and public confidence in the profession. The Registrant has not demonstrated any understanding as to why the misconduct occurred and how it

could be avoided in future. There is no evidence of reflection, training or continuing professional development. The Committee therefore concludes that there is a risk of repetition of her misconduct, including her dishonesty.

65. Were the conduct to be repeated there would be a risk of harm to patients and the public; it is of overriding importance that registrants act honestly in the course of their practice. The failure to adhere to good pharmacy practice has the potential to put patients at risk of harm. There is no evidence of actual harm in this case but the circumstances of the dishonest conduct are such that harm could have been caused.

66. The wider public interest (ie maintaining public confidence and upholding professional standards) requires a finding of impairment because there is a risk of future harm. A finding of impairment is also necessary to mark the seriousness of what has occurred and thereby maintain public confidence and promote professional standards by making clear to other professionals what is expected and deterring other professionals from failing to meet standards.

67. The Committee therefore finds the Registrant's current fitness to practise is impaired on grounds of public protection and the wider public interest. It concludes that Rule 5(2)(a)-(d) are engaged in this case: the Registrant presents an actual or potential risk to patients or to the public; she has brought, and might bring, the profession of pharmacy into disrepute; she has breached one of the fundamental principles of the profession of pharmacy and her integrity can no longer be relied upon.

Decision on Sanction

68. Having found impairment, the Committee has gone on to consider the matter of sanction. The Committee's powers are set out in Article 54(2) of the Order. The Committee should consider the available sanctions in ascending order from the least restrictive, taking no action, to the most restrictive, removal from the register, in order to identify the appropriate and proportionate sanction that meets the circumstances of the case.

69. The purpose of the sanction is not to be punitive, though a sanction may in fact have a punitive effect. The purpose of the sanction is to meet the overarching objectives of regulation, namely the protection of the public, the maintenance of public confidence and to promote professional standards. The Committee is therefore entitled to give greater weight to the public interest over the Registrant's interests.

70. The Committee had regard to the Council's '*Good decision making: Fitness to practise hearings and outcomes guidance',* revised March 2024, to inform its decision.

71. The Committee took into account the submissions made by Ms Tompkinson and the documentation submitted by the Registrant. It has not heard oral evidence at this stage of the proceedings but has had regard to earlier evidence in all its forms. Ms Tompkinson submitted that the appropriate sanction in this case was that of

removal. In the interests of fairness to the absent Registrant, in addition to making submissions on behalf of the Council, Ms Tompkinson referred to the evidence of the Registrant which might assist her case.

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

73. The Committee identified some aggravating factors, including:

    a. The misconduct occurred in the course of pharmacy practice.

    b. There were repeated occasions of misconduct, including dishonesty, in the course of March-April 2021.

    c. The misconduct gave rise to the deliberate misdirection of pharmacy colleagues as to steps that had been taken, such that it appeared clinical checks had been undertaken when they had not.

    d. There was gross abuse of the Registrant's employer's and pharmacy colleagues' trust.

    e. The Registrant's behaviour was premeditated; it was not opportunistic.

    f. There remains a risk of repetition of the misconduct, including dishonesty.

    g. The misconduct gave rise to a risk of potential harm to patients (albeit there is no evidence of such harm).

74. The Committee identified some mitigating features including:

    a. The misconduct occurred over a relatively short period of about two months in 2021.

    b. The misconduct was not for personal gain; the Registrant may have had good intentions, namely to speed up the process of delivering medications to patients in a time-pressured environment.

    c. The Registrant had returned to work after a period of extended sick leave; she felt that her health issues were not being appropriately addressed by her employer.

    d. These events occurred during the Covid-19 pandemic when pharmacy staff had heavy workloads.

    e. There is no evidence of previous adverse fitness to practise issues. The Registrant had an unblemished record as a pharmacy technician.

    f. The Registrant cooperated to some extent with these proceedings albeit not fully.

    g. The Registrant has produced positive testimonials from work colleagues and others. Some of the authors are aware of the allegations.

75. The Committee takes into account the Registrant has not practised for a considerable time; she is not currently practising due to restrictions on her registration and her desire to leave the profession. She has not therefore had the opportunity to demonstrate remediation of her practice during the course of these proceedings. That said, she has not shown any inclination to remediate her misconduct; she has not provided any reflection on her conduct.

76. The Committee has had regard to the mitigating and aggravating features at each stage of its decision-making on the appropriate and proportionate sanction. It has also had regard to the positive testimonials. While they do not all refer specifically to the allegations in this case, it is likely the authors are aware of them in general terms because the Registrant was disciplined by her employer, a matter which is likely to be known to the authors. The testimonials warrant evidential weight.

77. Throughout its consideration of an appropriate sanction, the Committee has had in mind the issue of proportionality, weighing the interests of the public against those of the Registrant.

78. This is not a case where no action can be taken: members of the public, with knowledge of the misconduct and the circumstances in which it took place, would be surprised were no action to be taken, particularly as dishonest conduct occurred in the course of pharmacy practice and may have continued had her employer not initiated disciplinary proceedings and reported concerns to the Council.

79. The Committee decided against imposing a warning because the Registrant's misconduct was too serious for such a limited response. She has demonstrated no significant insight or remediation and her misconduct involved breaches of various professional standards to which the Registrant was expected to adhere as a registered pharmacy technician. A warning would serve as a public acknowledgement that the misconduct was unacceptable, but it is not sufficient to mark the damage done to the reputation of the profession and the extent to which public confidence in the profession will have been damaged by the Registrant's dishonesty in the course of her pharmacy practice. Furthermore, pharmacy colleagues within the pharmacy profession would expect a restrictive sanction to be imposed to mark the detrimental impact of the Registrant's dishonest conduct within the workplace.

80. The Committee next considered whether to impose conditions on the Registrant's registration but determined this was not appropriate given the Registrant's failure to engage meaningfully with these proceedings; she did not give oral evidence at the facts stage and has voluntarily absented herself at the second and third stages of these proceedings. There is no indication from the evidence before the Committee that the Registrant would be willing to adhere to conditions were they to be imposed on her registration. In any event, conditions would not be workable or practicable in this case because the Registrant's activities were conducted clandestinely. Nor would conditions be sufficient to address the wider public interest in this case.

81. With regard to the option of suspension, the Committee noted from the "*Good decision making: fitness to practise hearings and outcomes guidance"* that suspension may be appropriate to highlight to the profession and the public that the conduct of the Registrant was unacceptable and unbefitting a member of the pharmacy profession. It might also be appropriate when public confidence in the profession demanded no lesser sanction.

82. There is specific guidance on the issue of dishonesty:

> "6.8. 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 pharmacy professionals. 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.
>
> 6.9. Some acts of dishonesty are so serious that the committee should consider removal as the only proportionate and appropriate outcome. This includes cases that involve intentionally defrauding the NHS or an employer, falsifying patient records, or dishonesty in clinical drug trials.
>
> 6.10. When deciding on the appropriate outcome 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."

83. The Committee has had regard to the context of the dishonest conduct. This was dishonesty in the workplace, in a pharmacy setting, in the course of pharmacy practice. It involved a gross breach of trust between the Registrant and her pharmacist colleagues and her employer. The dishonest conduct was not for personal gain but appears to have been to short-circuit the safety net provided by a pharmacist's clinical check in the process of dispensing and issuing medications to patients. The Registrant falsified the initials of pharmacists on several occasions over a two month period. She failed to ensure the relevant prescriptions had been clinically checked by a pharmacist. She had intended to give the impression that the prescriptions had been clinically checked by a pharmacist. Her actions were dishonest and deceitful; they misled her colleagues into thinking that due process had been followed when it had not. Her actions put the health of patients at risk of

harm. There was no financial loss arising from the Registrant's misconduct. She knew what she was doing was wrong. She has continued to deny the allegations. At material times, the Registrant was unhappy about the manner in which her employer had addressed her health issues and their impact on her work.

84. While the dishonesty was very serious indeed, it was not at the highest end of the spectrum of seriousness. There was, for example, no financial gain for the Registrant. That said, the dishonesty involved the falsification of patient records and misled professional colleagues into believing that due process had been followed. The dishonesty was therefore at the upper end of the spectrum of dishonesty, albeit not at the top.

85. It is highly significant that the Committee has found there is a risk of repetition of the dishonest conduct as set out in its determination at the impairment stage.

86. The public interest includes protecting the public, maintaining public confidence in the profession and maintaining proper standards of behaviour. It is not the purpose of this Committee to punish the Registrant but the Committee is entitled to give greater weight to the need to protect the public and the wider public interest than the Registrant's own interests.

87. The maximum period of suspension which the Committee can impose is 12 months. The Committee has borne in mind the mitigating and aggravating factors.

88. As a practising registered pharmacy technician, the Registrant should have been alive to the potential detrimental impact her actions might have on safe pharmacy practice and that there was a risk of error/s being missed; such errors might have led to patient harm. The Registrant's actions are likely to have damaged public confidence in the profession and its reputation. They have the potential to taint the reputations of her pharmacy colleagues, including the responsible pharmacists concerned. The Registrant's conduct was significantly and markedly below the standards expected of a registered pharmacy technician. The Committee considers that significant weight must be given to the need to protect the public and to uphold public confidence in the profession and to maintain proper standards within the profession. It is also important to deter other members of the profession from acting as the Registrant did in early 2021: they should be warned that such significant failures to adhere to SOPs (which are put in place to ensure safe pharmacy practice) may have a detrimental impact on safe practice and are wholly unacceptable. Members of the public and the pharmacy profession can no longer trust the Registrant to prioritise the interests of her patients over her own interests.

89. There is no evidence to suggest that, if the Registrant's practice were suspended, she would gain insight, show remorse or take steps to remediate her misconduct in the interim. The Registrant has herself said she does not intend to return to practice.

90. The Committee has therefore concluded that even the maximum period of suspension, with a review of her fitness to practise after a period of 12 months'

suspension, would not be sufficient to mark the overriding objectives of this Committee and the regulatory process. A more serious sanction is warranted by the seriousness and circumstances of the Registrant's misconduct in pharmacy practice and the risk of repetition if the Registrant were to return to practice as a pharmacy technician (albeit she has indicated it is not her intention to do so).

91. The Committee therefore turned to the option of removal and noted the guidance as to when this sanction was appropriate.

92. A prescription is a patient record; it serves to indicate the medication which has been prescribed for that patient. The guidance makes it clear that certain misconduct warrants removal: "Some acts of dishonesty are so serious that the committee should consider removal as the only proportionate and appropriate outcome. This includes cases that involve intentionally … falsifying patient records…". This is such a case. Falsification of prescriptions is fundamentally incompatible with continued registration.

93. The Registrant told the Committee she did not intend to practise again as a pharmacy technician. Nonetheless, removal would prevent the Registrant from returning to practice if she subsequently chose to do so; there would also be reputational damage for the Registrant. There is no evidence to suggest that the Registrant's ability to earn a living would be damaged by removal or that there would be any detrimental financial implications for her if her name were removed from the register.

94. The Committee acknowledges this is the most serious sanction and that it is reserved for the most serious cases. The Committee has had regard to the Registrant's evidence and submissions, including her comments (by reference to exhibits) on the facts found proved in this case. Her documentary evidence and submissions do not justify or explain her dishonest conduct in relation to the dispensing of prescriptions and issue of medication without proper checks. The Committee has borne in mind the impact of removal on the Registrant's own interests. However, these are very serious matters which undermine safe pharmacy practice and the public interest outweighs the Registrant's own interests. The Committee considers that informed members of the public and the profession would be shocked if the Committee took any lesser step than to remove the Registrant's name from the Register given the risk of repetition if she were to return to pharmacy practice. The Committee concludes that the Registrant's dishonest conduct, in the absence of remediation, warrants the most serious sanction of removal.

95. In summary, the Committee has determined, on public protection and wider public interest grounds, to remove the Registrant's name from the Council's register.

Interim Order

96. The current interim order of suspension is hereby revoked.

Decision on Interim Measures

97. Ms Tompkinson made an application for interim measures under Article 60 of the Pharmacy Order 2010.

98. The decision to remove the Registrant's name from the Council's register will not take effect until 28 days after she is formally notified of the outcome, or until any appeal is concluded. Until the conclusion of that period the Registrant would be free to practise without restriction.

99. The Committee is satisfied that an interim measure suspending the Registrant's registration is necessary in the interests of public protection and is otherwise in the public interest, given the risk of repetition (notwithstanding the Registrant is not currently practising as a pharmacy technician and has no intention of doing so). It is required to maintain public confidence in the pharmacy profession. To determine otherwise would be inconsistent with the Committee's decisions on impairment and sanction.

100. The Committee imposes the interim measure of suspension accordingly.

101. This concludes the determination.