General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

In person at General Pharmaceutical Council,

One Cabot Square, Canary Wharf, London E14 4QJ and part Remote videolink hearing

13-21 May 2024, 28 May–6 June 2024, 17 June 2024 and 25-27 June 2024

Registrant name:	Mahmoud Muhiyye
Registration number:	2211528
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Lubna Shuja (Chair) Jignesh Patel (Registrant member) Wendy Golding (Lay member)
Committee Secretary:	Chelsea Smith & Gemma Staplehurst
Registrant:	Present and represented by Kevin McCartney, Counsel
General Pharmaceutical Council:	Represented by Christopher Geering, Counsel
Facts proved:	1 (only in relation to Items 12, 13, 14, 15, 16, 17, 18, 19, 20, 23, 26, 61, 62, 63, 65 and 66 of Schedule A), 2.1 (only in relation to Items 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 26, 61, 62, 63, 65 and 66 of Schedule A) 3.1, 4, 5, 10.4, 12.1
Facts proved by admission:	2.2
Facts not proved:	6, 7, 8, 9, 10.1, 10.2, 10.3, 11, 12.2, 12.3, 13
Fitness to practise:	Impaired

Outcome: Suspension Order of 5 months

This decision including any finding of facts, impairment and sanction is an appealable decision under *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010*. Therefore, this decision will not take effect until 26 July 2024.

Particulars of Allegation (as amended)

You, a registered pharmacist, and the Responsible Pharmacist (RP), Superintendent Pharmacist (SI) and a director of Stockport Healthcare Limited trading as Cale Green Pharmacy, Stockport located at Longshut Lane, Stockport, and then at 145 Shaw Heath Stockport, were responsible for the safe and effective delivery of services from the pharmacy from around January 2018 to around August 2019.

1. *On one or more of the dates indicated in Schedule A you caused or allowed the following to be supplied or sold while there was no pharmacist on the premises:*

    1.1. Controlled Drugs,
    1.2. Prescription-only medicines other than Controlled Drugs,
    1.3. Pharmacy medicines;

2. *With regard to Allegation 1:*
    2.1. on one or more occasions you failed to supervise the supply or sale of the products adequately in that you used an electronic messaging system to check the medication and/or to instruct the supply or sale of the items while you were not on the premises,
    2.2. you caused or allowed confidential patient information to be held on private electronic devices; **[ADMITTED]**

3. *On one or more occasions on dates unknown you:*
    3.1. caused or allowed patients to be supplied with, and take home, medication requiring supervised consumption,
    3.2. [Withdrawn]

4. *You failed to ensure safe custody of Controlled Drugs in that you did not adequately control access to the keys for the Controlled Drugs cabinet;*

5. *On the occasion in Schedule B you claimed payment for an item which had not been supplied;*

6. *Your actions as set out in Allegation 5 above were dishonest in that you knew the item had not been supplied to the patient;*

7. *On one or more of the occasions set out in Schedule C, you created, or caused to be created, fraudulent Medicine Use Reviews ("MURs") in that a review had not been undertaken;*

8. *On one or more occasions you submitted or allowed to be submitted, an FP34 form to claim fees for fraudulent MURs in Schedule C and / or Schedule D;*

9. *Your actions at Allegations 7 and/or 8 above were dishonest in that you knew that the MURs had not been undertaken and / or the pharmacy was not entitled to payment;*

10. *You created false records for the pharmacy in that you, on one or more occasions:*

    10.1. instructed staff not to record near misses and/or dispensing errors,
    10.2. created or caused to be created false reports of near-misses,
    10.3. created or caused to be created false reports of medication errors,
    10.4. when acting in the role of RP, failed to record your absences from the pharmacy in the RP log;

11. *Your actions as set out in Allegations 10.1 and/or 10.2 and/or 10.3 and/or 10.4 were dishonest;*

12. *You failed to ensure the safe and effective delivery of services in the pharmacy in that you:*

    12.1. employed inexperienced staff and then instructed them to act beyond their competency,
    12.2. lied to, or instructed staff to lie to, people who came to the pharmacy,
    12.3. continued to use a Smartcard assigned to Person C after she had ceased to be employed at the pharmacy;

13. *Your actions as set out in Allegation 12.2 were dishonest.*

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

<u>Schedule A</u> – sale or supply of prescription-only medicines, Controlled Drugs and pharmacy medicines without a pharmacist on the premises

1.	Monday	28.01.19	11.00	Fexofenadine, Clobetasol
2.	Tues/ Weds	29.01.19	09.30	Doxycycline
3.	Thursday	31.01.19	09.16	Desogestrel, Miconazole Nitrate
4.	Monday	11.02.19	14.24	Lactulose

5. Monday 25.03.19 11.51 Pivmecillinam, Timodine cream
6. Monday 25.03.19 11.51 Tramadol
7. Tuesday 26.03.19 11.22 Co-Codamol
8. Tuesday 26.03.19 12.15 Sumatriptan, Naproxen
9. Tuesday 26.03.19 12.21 Diazepam
10. Tuesday 26.03.19 17.00 Lymecycline
11. Tuesday 26.03.19 17.06 Metformin, Aspirin
12. Wednesday 27.03.19 10.08 Lansoprazole
13. Wednesday 27.03.19 16.29 [Ispagel GSL- agreed facts no pharmacist required], Hyoscine butylbromide
14. Thursday 28.03.19 11.24 Zapain
15. Thursday 28.03.19 13.44 Allopurinol
16. Friday 29.03.19 15.45 Glyceryl Trinitrate Spray
17. Friday 29.03.19 15.51 Codeine Phosphate, Nicorette
18. Friday 29.03.19 16.07 Chloramphenicol
19. Tuesday 02.04.19 08.48 Amoxicillin
20. Tuesday 02.04.19 12.10 Clarithromycin, Prednisolone
21. Tuesday 02.04.19 14.40/41 Levothyroxine, Pravastatin, Aspirin
22. Tuesday 02.04.19 14.47 Dossett box
23. Monday 08.04.19 13.42 Clobetasone
24. Tuesday 09.04.19 14.47 Amoxicillin
25. Thursday 11.04.19 13.24 Bendroflumethiazide, Citalopram, Lansoprazole, paracetamol
26. Wednesday 18.04.19 12.53 Sertraline
27. Tuesday 23.04.19 09.50 Rozex
28. Tuesday 23.04.19 10.09 Fexofenadine, Avamys (emergency prescription)
29. Wednesday 24.04.19 11.31 Amoxicillin, Prednisolone, Ventolin inhaler, Trelegy ellipta
30. Thursday 25.04.19 12.02 Fluoxetine
31. Thursday 25.04.19 16.23 Methadone
32. Friday 26.04.19 10.48 Fenbid Forte
33. Friday 26.04.19 14.01 Desogestrel
34. Monday 29.04.19 12.30 Gaviscon
35. Monday 29.04.19 15.13 Prednisolone
36. Wednesday 01.05.19 11.58 Amoxicillin
37. Wednesday 01.05.19 15.16 Paracetamol
38. Thursday 02.05.19 13.01 Morphine, Trimbow

39. Thursday 02.05.19 13.04 Pregabalin, Chloramphenicol
40. Tuesday 07.05.19 11.25 Hydrocortisone cream, Betamenthasone
41. Thursday 09.05.19 12.57 Sertraline
42. Monday 13.05.19 10.40 Betnovate, Doxycycline
43. Monday 13.05.19 10.46 [Nicotine GSL – agreed facts no pharmacist required]
44. Monday 13.05.19 10.55 Amoxicillin
45. Monday 13.05.19 10.58 Folic Acid
46. Monday 13.05.19 11.04 Naproxen, Lansoprosole, Gabapentin
47. Monday 13.05.19 11.13 Amoxicillin
48. Monday 13.05.19 11.13 Fluclaxacillin, Hydromol ointment
49. Tuesday 14.05.19 15.26 Lansoprazole, Salbutamol
50. Thursday 16.05.19 14.27 Levothyroxine
51. Friday 17.05.19 15.25 Amoxicillin
52. Friday 17.05.19 16.03 Propanolol, Citalopram
53. Monday 20.05.19 09.20 Children's Ibuprofen
54. Monday 20.05.19 10.39 Prednisolone, Amoxicillin, Chloramphenicol
55. Monday 20.05.19 10.40 Tamsulosin
56. Monday 20.05.19 11.08 / 11.19 Methadone
57. Monday 20.05.19 13.08 Clenil modulite
58. Monday 20.05.19 17.37 Mirtazapine
59. Monday 20.05.19 17.43 Beconase Aqueous
60. Monday 20.05.19 18.03-05 Methadone
61. Tuesday 21.05.19 11.21 Opthalmics Ltd, Ramipril, Seretide
62. Tuesday 21.05.19 15.12 Codeine phosphate
63. Tuesday 21.05.19 16.35 Terbinafine
64. Wednesday 22.05.19 09.12 [Sodium bicarbonate – agreed facts not a medicinal product]
65. Wednesday 22.05.19 10.18 Amoxicillin
66. Wednesday 22.05.19 14.54 Propranolol
67. Wednesday 22.05.19 15.17 Nitrofurantoin
68. Wednesday 22.05.19 15.37 Clarithromycin
69. Tuesday 28.05.19 11.28 Flucloxacillin
70. Tuesday 04.06.19 10.22 Flucloxacillin
71. Friday 14.06.19 10.09 Aspirin, Atenolol, Ezetimibe
72. Friday 14.06.19 16.03 Zopiclone

Schedule B – payments for items not dispensed

1. 3 December 2018 to 5 March 2019 – in relation to Person B

Schedule C

1. 16 November 2011 (supposed to be 2018) – in relation to Patient 1 (Supported living facility)
2. 3 August 2018 – in relation to Patient 3 (Supported living facility)
3. 3 August 2018 – in relation to Patient 4 (Supported living facility)
4. 16 October 2018 – in relation to Patient 2 (Supported living facility)
5. [Withdrawn]
6. 19 December 2018 – in relation to Patient 6
7. 29 January 2019 - in relation to Patient 6.
8. 31 May 2019 – in relation to Patient 5
9. 16 July 2019 – in relation to Patient 5
10. 19 April 2019 – in relation to Patient 377
11. 19 April 2019 – in relation to Patient 378
12. 19 April 2019 – in relation to Patient 379
13. 19 April 2019 – in relation to Patient 337
14. 6 May 2019 – in relation to Patient 380
15. 18 October 2018–- in relation to Patient 381
16. 21 January 2019 – in relation to Patient 382
17. 15 January 2019 - in relation to Patient 383
18. 4 January 2019 - in relation to Patient 384
19. 2 September 2019 – in relation to Mahmoud Muhiyye

Schedule D

1. March 2019 – in relation to 7 patients claimed for, for which there is no record of a MUR having taken place
2. July 2019 – in relation to 7 patients claimed for, for which there is no record of a MUR having taken place

Documentation

- GPhC Hearing Bundle Part 1 (957 pages)
- GPhC Hearing Bundle Part 2 (139 pages)

- Index to GPhC Hearing Bundle (8 pages)
- GPhC Revised Statement of Case dated 12 May 2024
- Provisional Timetable
- The Registrant's Bundle (191 pages)
- The Registrant's Document 2 (1 page)
- Agreed Facts dated 30 May 2024
- The Council's Closing Submissions dated 30 May 2024
- The Council's Guidance Document provided on 31 May 2024

Witnesses

Person C - gave evidence at facts stage

VR - gave evidence at facts stage

Witness A - gave evidence at facts stage

Patient 6 – gave evidence at facts stage

Witness B, Support Worker – gave evidence at facts stage

Witness C, Service Leader – gave evidence at facts stage

The Registrant – gave evidence at facts stage

Determination

Introduction

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

2. The matter concerns Mahmoud Muhiyye ('the Registrant') who is registered with the Council as a Pharmacist registration number 2211528.

3. 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").

4. 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.

5. The Committee also has regard to the guidance contained in the Council's *Good decision making: Fitness to practise hearings and outcomes guidance* as revised March 2024.

6. 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

7. A letter dated 3 April 2024 from the Council headed 'Notice of Hearing' was sent to the Registrant. No issue was taken by either party with service. The Committee was satisfied that there had been good service of the Notice in accordance with Rules 3 and 16.

The Council's Application for Special Measures

8. Mr Geering, on behalf of the Council, made an application for special measures in relation to Person C and Patient 6. He stated that Person C was vulnerable due to her health. She would be giving evidence in person. Mr Geering requested her identity be anonymised and that she be permitted to be screened when giving her evidence.

In relation to Patient 6, Mr Geering confirmed she would be giving evidence remotely and requested her identity also be anonymised to protect her privacy.

9. Mr McCartney, on behalf of the Registrant, confirmed there was no objection to the application for special measures.

10. The Committee noted the application was agreed. It noted there were health issues relating to two witnesses, Person C and Patient 6. Person C had been described as vulnerable due to her medical condition and Patient 6's medical details had been mentioned in her statement. Both witnesses were entitled to have their privacy protected and it appeared Person C would require the use of a screen to enable her to be able to give her evidence. There was no objection from the Registrant. In the circumstances the Committee granted the application for special measures to allow both Person C and Patient 6 to be anonymised to protect their privacy and for Person C to use a screen when giving her evidence for health reasons.

The Council's Application to amend the Allegations

11. The Committee heard an application from Mr Geering, on behalf of the Council under Rule 41 to amend Allegations 1, 5, 6, 7, 8, 9 and 13 as follows:

- Allegations 1 and 5 – Mr Geering confirmed that these Allegations had been pleaded with the words "*and/or on dates unknown"*. He accepted that the Allegations should be specific about dates, in fairness to the Registrant and therefore he applied to remove these words.
- Allegation 5 – Mr Geering applied to amend the word "*items*" to "*item*" on the basis that Schedule B in that Allegation referred to a single item. Mr Geering also applied to remove the words "*namely prescribed items*" again on the basis that the Council's case relied on a single item.
- Allegation 6 – Mr Geering applied to amend the word "*items"* to "*item"* for the same reasons given as in Allegation 5, namely that the Council's case relied on a single item.

- Allegation 7 – Mr Geering applied to remove the words "*and/or on dates unknown"* for the same reasons as in Allegations 1 and 5. The Registrant had requested the Council specify what evidence it relied upon for this Particular. This had led to amendments to Schedule C. Mr Geering therefore also applied to remove reference to an Medicine Use Review ("MUR") concerning Patient 7 in Schedule C. Mr Geering confirmed that the Council no longer relied on Patient 7, who had initially been contacted by NHS England when they were investigating the MURs. Patient 7 was subsequently contacted by the Council, but had not been happy with the evidence from NHS England and did not wish to support the allegation as that patient did not have any criticism of the Registrant.
- Allegation 8 – Mr Geering confirmed this related to FP34 Claim Forms. He applied to remove the word "*the"* before and add the words "*Schedule C and/or Schedule D"* after the words *"fraudulent MURs".* Mr Geering confirmed the Council had added a further number of MURs to Schedule C and FP34 Forms to Schedule D as the Council relied on additional further incidents where it was alleged that there had been a failure to undertake reviews and fraudulent FP34 Forms were alleged to have been submitted.
- Allegation 9 – Mr Geering applied to add the words *"/or"* after *"and.."* and before *"the pharmacy…"* to make it clear that the Committee could find this Particular in the alternative and it was not necessary to find both parts proved.
- Allegation 13 – Mr Geering applied to correct a grammatical error to amend the word *"was"* before *"dishonest"* to "*were".*

12. Mr Geering accepted that some of the proposed amendments meant there would be an impact on the Council's Hearing Bundle. He confirmed that late last week there had been additional significant disclosure of unused material to the Registrant which the Registrant and his representatives would need time to consider.

13. Mr McCartney, on behalf of the Registrant, confirmed there was no objection to the application for amendments. The parties had been in discussion for some time about these issues and there had been a Case Management Meeting ("CMM") on

Friday 10 May 2024. The outcome of that CMM now had to be considered in relation to the documents relied upon. This had been the first opportunity for the parties to re-consider the documents following the CMM. Mr McCartney stated that there may be some paragraphs in documents that needed to be redacted and other documents where redactions could be removed. This would take a little time. Mr McCartney also confirmed that the Registrant needed to draft and submit a Supplementary Statement to deal with the additional matters raised. This was likely to take a few hours and the Committee would also need time to consider the additional documents.

14. The Committee noted the amendments were agreed. They related either to minor typographical errors, or making the case against the Registrant clearer by specifying dates and documents the Council sought to rely upon. It was in the interests of justice and of a fair hearing that the Registrant was clear about the facts relied upon. The Committee therefore granted the application for the various amendments as set out.

The Council's Second Application to Amend the Allegations

15. At the close of the Council's case, Mr Geering made a further application to amend the Allegations. He applied to delete Allegation 3.2 altogether. The Council had relied on the evidence of VR to support this Allegation. Having heard her evidence, Mr Geering submitted it was no longer appropriate for the Registrant to face this Allegation as it was clear from her evidence that Patient 8 had attended only once and it was now known that he not been supplied with the specific medication referred to in the Council's Statement of Case. Although Person C had referred to medication being given early to Patient 8, this was not the basis upon which this case had been put by the Council. Mr Geering submitted it was in the public interest to delete Allegation 3.2.

16. Mr Geering also applied to amend Allegations 5 and 6. Both Allegations referred to an item being "*dispensed*" rather than "*supplied*". In Allegation 5, Mr Geering

applied to amend the word "dispensed" to "*supplied*" and in Allegation 6 he applied to remove the word "*dispensed*" as "*supplied*" was already pleaded in that Allegation. Mr Geering submitted that Person C's evidence had made it clear that although the medication mentioned in these Allegations had been labelled, prepared and placed in a bag, it had never been given to the patient. The suggested amendments were to clarify that the medication had not been supplied to the patient.

17. Mr McCartney confirmed, on the Registrant's behalf, that the amendments were not opposed. There was no objection to the deletion of Allegation 3.2. In relation to Allegations 5 and 6, Mr McCartney confirmed the Registrant had carefully considered if these amendments would result in unfairness to him. Mr McCartney confirmed that he would not have conducted the case any differently if the word "*supplied*" had been used. He accepted the Council's case had always been on the basis that the medication had not been supplied to Person B and that it was alleged the Registrant had made a claim knowing this when he was not entitled to make that claim. On that basis, Mr McCartney confirmed he would not have done anything differently and so did not object to the amendments sought.

18. The Committee carefully considered the application. It noted the application had been made to reflect the evidence it had heard and that the amendments were agreed by the Registrant who had accepted they would not cause unfairness to him. Mr McCartney had fairly conceded that the amendments did not impact on the way in which he had already conducted the Registrant's case and that his cross-examination of the witnesses would not have been any different if the amendments had been made earlier. It was unusual for Allegations to be amended at such a late stage but the Committee was satisfied that, in this case, allowing the withdrawal of Allegation 3.2 and the amendments to Allegations 5 and 6 would not prejudice the Registrant and were in the public interest. It therefore granted the amendments sought.

The Council's Application to Amend Schedule C referred to the Allegation

19. After the Registrant had completed giving evidence, Mr Geering, on behalf of the Council, made an application to amend the date referred to at item 19 on Schedule C which concerned the Medicine Use Review ("MUR") on the Registrant. The date given in Schedule C was 4 September 2019, but during the Registrant's evidence it became clear from the MUR Summary Report that the date of this MUR was actually 2 September 2019. Mr Geering applied to amend the date from 4 September 2019 to 2 September 2019 to reflect the evidence before the Committee.

20. Mr McCartney, on behalf of the Registrant, confirmed he did not object to the amendment. The documents confirmed that Pharmacist 1 had been the Responsible Pharmacist that day so the amendment would not cause unfairness to the Registrant.

21. The Committee took into account the amendment was agreed by both parties and had arisen as a result of a closer analysis of the MUR Summary Report. It was satisfied that allowing the amendment at this late stage would accurately reflect the contemporaneous documents and was in the public interest. Mr McCartney had accepted there would be no prejudice to the Registrant. Accordingly, the Committee allowed the amendment.

Application for the hearing to be held in Private

22. During the course of the hearing, it became apparent that there would be references to the health of various witnesses. The Committee proposed, under Rule 39(3) of the Rules to hold those parts of the hearing in private. Neither party objected to this course of action.

23. Accordingly, the Committee decided to hold certain parts of the hearing in private where there were references to the health of any identifiable witnesses in order to protect their privacy.

The Registrant's response to the Allegation

24. The Registrant admitted Allegation 2.2. Accordingly, the Committee found Allegation 2.2 proved under Rule 31(6) of the Rules.

25. The Committee went on to receive evidence and submissions regarding the remaining disputed Allegations.

Background

26. The Registrant qualified as a Pharmacist on 1 August 2016.

27. On 1 June 2018, Stockport Healthcare Limited ("the Company") purchased Cale Green Pharmacy ("the Pharmacy") at Longshut Lane, Stockport ("the old premises"). The Registrant was a joint director and shareholder of the Company and became the nominated Superintendent Pharmacist ("SI"). At the relevant times he was the Responsible Pharmacist ("RP") at the Pharmacy.

28. On or about 24 August 2018, Person C was employed by the Registrant as a Trainee Dispenser at the Pharmacy. Prior to this, she had been working as a Care Assistant in a Care Home.

29. VR worked at the Pharmacy at the old premises as a part-time qualified Dispenser. Her employment with the Pharmacy ended around November 2018.

30. On 15 February 2019, the Pharmacy relocated to 145 Shaw Heath, Stockport ("the new premises").

31. JR, who was a patient of the Pharmacy and who at the material time was also Person C's boyfriend, received a Penalty Charge Notice dated 21 May 2019 in the sum of £105.60. The Notice stated that the Charge was for the following reason:

> "*An automated check has shown that on or between 03 December 2018 and 05 March 2019 you claimed a free NHS prescription.*
>
> *This was because your submitted claim said you held a valid Pre-Payment Certificate.*

As we have not been able to confirm that you are entitled to claim free prescriptions at the time, you have been sent this Penalty Charge Notice."

32. On a date after 21 May 2019, the Registrant gave Person C some money to give to JR for the Penalty Charge.

33. Person C's employment at the Pharmacy ended on or around 20 June 2019. She had worked at both the new premises and the old premises.

34. On 22 July 2019, Person C submitted a complaint to NHS England and on 25 July 2019 she submitted a report to the Council in which she raised a number of concerns about the Registrant and the way in which he had been managing the Pharmacy. Her allegations included the following:

- *"Mahmoud would leave untrained, unqualified dispensers in the pharmacy for hours without any pharmacist supervision. Sometimes not even turning up. Mahmoud would ask us to still dispense and give out prescriptions, including methodone [sic] and other controlled drugs as long as went [sic] sent pictures of our dispensing over WhatsApp."*
- The Registrant had fraudulently filled out pharmacy records and documents.
- The Registrant had claimed for prescriptions that were not collected or required by the patient.
- The Registrant was alleged to have lied and hidden from patients who wanted to see or speak to him.
- The Registrant had allowed a supervised patient who was on a "*blue prescription*" to take home his medication rather than supervising the patient while he was in the shop.

35. On 29 July 2019, Witness A, who at that time was Senior Primary Care Manager for the NHS England Team in the Greater Manchester Health and Social Care Partnership, undertook an unannounced visit at the Pharmacy with a Controlled Drugs Liaison Officer. During the course of Mr Witness A's investigation, the further following concerns were raised:

- The Pharmacy was alleged to be operating and delivering NHS pharmaceutical services during NHS commissioned hours without a pharmacist on the premises
- There was alleged to be a failure to ensure the safe custody of Controlled Drugs and keys for the Controlled Drugs Cabinet
- Potential fraudulent claims regarding NHS prescription dispensing and advance pharmacy service Medicine Use Reviews ("MURs")
- The Registrant was alleged to be routinely employing individuals with no previous experience in pharmacy to work as dispensers and instructing them to complete tasks outside of competency
- Alleged falsification of pharmacy records such as the RP Log, medication error reports and near miss logs
- The Registrant was alleged to have failed to manage patient queries and complaints relating to medication queries
- There appeared to be information governance breaches regarding the use of Person C's Smartcard at the Pharmacy.

36. On 27 August 2019, the Registrant resigned as the SI and was no longer working at the Pharmacy. He also removed himself as director of the company and was no longer involved with the Pharmacy.

37. On 28 April 2021, the Registrant was interviewed by Pauline Smith and Witness A of the NHS Counter Fraud Authority at Stockport Police Station.

Submissions from the Parties

38. At the end of the Registrant's case, the parties provided the Committee with an Agreed Statement of Facts which stated as follows:

> *"1. The Registrant has no previous convictions or disciplinary findings recorded against him.*

2. On the 16th of April 2024 person C and Katie Clarke, a solicitor at CMS acting for the GPHC, had the following conversation which was recorded by Katie Clarke:
KAHK stated that [Person C] had explained the physical impact from the PRIVATE [injury] and asked if there was anything else that would impact on her being able to give evidence for example, her memory? [Person C] stated that she has not seen any issue with her memory PRIVATE.

3. In relation to Schedule A of the Particulars of Allegation, the following are GSL medication which may therefore be supplied in the absence of a pharmacist:
a. Ispagel (Schedule A, entry 13)
b. Nicotinen [sic] (Schedule A, entry 43)
Sodium Bircarbonate [sic] is not a medicinal product (Schedule A, entry 64)."

39. It was accepted by both parties that the record dated 16 April 2024 made by Katie Clarke and mentioned in the Agreed Facts had not specifically been put to Person C during her evidence, although Mr McCartney reminded the Committee that he had asked Person C questions about her memory. Mr Geering confirmed that the record from Ms Clarke dated 16 April 2024 was part of the Council's disclosure to the Registrant in relation to the application for Special Measures. The Registrant had been aware of it prior to the hearing. Mr Geering confirmed that he did not take the point that it had not been put to Person C during her evidence.

40. Mr Geering took the Committee though his written Closing Submissions dated 30 May 2024. These contained submissions about the credibility of witnesses as well as submissions on each of the Allegations. He submitted that whilst the Committee could consider the demeanour of witnesses, it must also take into account the contemporaneous records and measure the evidence it had heard against other documentary evidence, the accuracy of which was not disputed. He submitted it was possible for the Committee to find some aspects of a witness's evidence reliable and some not reliable. He accepted Person C's account had varied but submitted she had

not resiled from the fundamental issues on cross-examination. Mr Geering submitted VR's evidence was of limited value to the Committee as most of the Allegations concerned events after she had left the Pharmacy.

41. In relation to the Registrant, Mr Geering submitted his evidence had been unsatisfactory for a number of reasons which he explained. He submitted the Registrant's account was inherently improbable.

42. Mr Geering reminded the Committee that the test for dishonesty was contained in the case of Ivey v Genting Casinos [2017] UKSC 67 in which it was stated:

> "*When dishonesty is in question, the fact-finding Tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts……When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.*"

43. Both Mr Geering and Mr McCartney agreed that a good character direction was appropriate in this case in respect of (i) the Registrant's propensity to act in the manner alleged, and (ii) the Registrant's credibility. However, Mr Geering reminded the Committee that the weight given to an unblemished record may properly be less in the case of a registrant at an early stage in their career compared to one with an established track record, although inexperience may be a correspondingly weightier consideration in understanding what had happened.

44. Mr McCartney, on the Registrant's behalf, also made detailed submissions on the background to this case, the witnesses' evidence and each of the allegations. He took the Committee though the character references provided and submitted that the Registrant had not always got things right but that did not mean that he was dishonest.

45. Mr McCartney submitted the Registrant had been a bit out of his depth as a SI and he had not appreciated the dangers of managing staff adequately. The language used in the WhatsApp messages made it abundantly clear that professional boundaries had not been defined by anyone and Mr McCartney submitted this was fertile ground for the relationships between the Registrant, VR and Person C ending badly. He submitted that Person C had stated the Registrant had shouted at her but it had been clear over the last two days during the Registrant's evidence that his delivery and personality was not of someone who shouted. Mr McCartney submitted there had been a breakdown in the hierarchy boundary, Person C had a high opinion of herself and had become upset when the Registrant had not taken her opinion into account when he was making a decision to sack an employee who he thought was not doing her job properly.

46. Mr McCartney submitted that neither VR nor Person C were independent witnesses. They had both left the Pharmacy on bad terms, they had been on bad terms with each other and it was only after Person C left the Pharmacy and contacted VR, that they appeared to resolve their differences with the investigation into the Registrant. Mr McCartney submitted they both had a grudge against the Registrant, did not like him and felt he had not recognised their qualities and contributions. He reminded the Committee that VR had made allegations against the Registrant which had been subsequently withdrawn when the relevant Patient Medication Record ("PMR") had been produced as it confirmed her allegation was not true. He submitted this was an indication of the unreliability of her evidence.

47. In relation to Person C, Mr McCartney submitted that she had also not been able to remember precise details and that it was unfair of the Council to submit the Registrant was not telling the truth when he could not remember details but that Person C was mistaken when she couldn't remember details. Mr McCartney reminded the Committee that the Registrant was entitled to not agree with what had been put to him as he had a different interpretation of events. Mr McCartney submitted Person C had an excellent memory when she felt she was on strong ground but a poor memory when there was an inconsistency.

48. Mr McCartney referred the Committee to paragraphs 39-40 of the case of Dutta v General Medical Council [2020] EWHC 1974 (Admin) which also referred to Gestmin SGPS SA v Credit Suisse (UK) Ltd [2013] EWHC 3650 (Comm). He particularly drew the Committee's attention to the following:

> "*39 …..Gestmin …….. We believe memories to be more faithful than they are. Two common errors are to support (1) that the stronger and more vivid the recollection, the more likely it is to be accurate; (2) the more confident another person is in their recollection, the more likely it is to be accurate…….*
>
> *The best approach from a judge is to base factual findings on inferences drawn from documentary evidence and known or probable facts. "This does not mean that oral testimony serves no useful purpose… But its value lies largely in the opportunity which cross-examination affords to subject the documentary record to critical scrutiny and to gauge the personality, motivations and working practises of a witness, rather than in testimony of what the witness recalls of particular conversations and events. Above all, it is important to avoid the fallacy of supposing that, because a witness has confidence in his or her recollection and is honest, evidence based on that recollection provides any reliable guide to the truth" ……*
> *40. …….Of the five methods of appraising a witness's evidence, he identified the primary method as analysing the consistency of the evidence with what is agreed or clearly shown by other evidence to have occurred. The witness's demeanour was listed last, and least of all."*

49. Mr McCartney reminded the Committee that it had the WhatsApp messages, Responsible Pharmacist ("RP") records, invoices, and other contemporaneous documents such as patient records, but there were also matters where there was no evidence to support the allegations made. He submitted that what had really happened in this case was that Person C had picked things up very quickly in the Pharmacy, the Registrant had trusted her, she did well, she took on too much

responsibility and gained a misplaced sense of her own importance. He reminded the Committee that there had been at least one incident when Person C had been reluctant to accept the Registrant's advice, even though he was the pharmacist. She considered herself to be his "*golden ticket*" as she had stated in WhatsApp messages. Mr McCartney submitted the bubble had burst, their friendliness had turned sour and this had been fertile ground for limited genuine complaints being embellished, exaggerated and on occasion made up.

Decision on Facts

50. 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 Mr Geering on behalf of the Council and Mr McCartney, on behalf of the Registrant.

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

52. The Committee took into account the passage of time that has passed since the alleged events, in this case almost 6 years, and that witnesses cannot be expected to precisely remember every date and detail. The Committee is not required to make a determination on every disputed issue so it focussed on those material matters relevant to the Allegations, whilst taking into account the content of contemporaneous records and undisputed documents.

53. The Committee considered carefully the evidence given by each of the witnesses. The Committee was mindful that the Registrant was of previous good character and that this was relevant to his propensity to act as alleged and to his credibility. It took into account the character references provided which all spoke highly of the Registrant, his integrity, honesty and professionalism. The Committee was also mindful that the Registrant had qualified as a Pharmacist on 1 August 2016 and had therefore been qualified for only 2 years at the material time of the first alleged incident.

54. Person C was a Trainee Dispenser. It was clear from her evidence that she had initially got on very well with the Registrant, they had been "*close*" and they had had a good working relationship. She said the Registrant had been "*laid back"* from the start, they had *"banter"* but were well aware of where they stood professionally. The contemporaneous WhatsApp messages provided demonstrated they joked with each other frequently and at times conversed in a manner that could be described as extremely informal and unprofessional. On 5 December 2018, Person C had been enrolled onto a "Buttercups" healthcare assistant course which would give her two qualifications – a medicine counter assistant course and a dispensing assistant course. She passed a number of modules on this course but did not complete it and qualify whilst working at the Pharmacy.

55. Person C said that her role was central to the Pharmacy as she felt she "*was doing all the work, on my own, all the time so was the only one that customers saw regularly…. Customers really liked me, they would tell me this often and would bring me gifts and dinner….. Customers did love me."* She agreed she was not shy to take on new responsibilities but she said she felt asking her to train another new colleague was too much when she was still training herself.

56. In her witness statement dated 11 July 2023, Person C said that she had had an argument with the Registrant on 19 June 2019 which she said was a result of a "build up" following the way she felt she had been treated by him. In her witness statement she said that she had earlier asked the Registrant for a pay rise as she did not feel she was being sufficiently compensated for the amount and standard of work she was completing. Person C stated the Registrant offered her an extra 20p per hour if she took on another responsibility. In her witness statement, Person C stated that on 19 June 2019 the Registrant had shouted at her in English whilst intermittently speaking to someone else on the phone in another language. The following day, on 20 June 2019, she stated they had had a further discussion in the Pharmacy consultation room where she said the Registrant had made her feel uncomfortable. She stated she left the Pharmacy indicating to the Registrant that she "*needed a couple of days away from work*" and would return on Monday. She did not return to work after that date.

57. On cross-examination, Person C denied the argument on 19 June 2019 had been about a pay rise or that it had had anything to do with the Registrant speaking in Kurdish on the phone while laughing at her. She repeatedly stated he had been laughing at her whilst on the phone but said although she had been upset about the pay rise, their argument was because the Registrant had decided to fire Person A, an employee who Person C had been training. She said she had felt that she needed more help in the Pharmacy. This had not been mentioned in her witness statement. Person C stated she had not mentioned this in her witness statement because the other girl did not want to be involved. There were other details which she gave in her evidence which had not been in her witness statements.

58. During her evidence, Person C was able to recall quite specific details at times but was unable to remember other details on cross-examination. She made reference to her health condition, PRIVATE, for her lack of memory recall. During cross-examination she became very upset when asked about her memory and health condition. The Committee accepted events were from nearly 6 years ago and that a witness is unlikely to recall every detail. During questions from the Committee, Person C had stated there were some gaps in her memory due to her medical condition, but in the contemporaneous record made by the Council's solicitor on 16 April 2024, Person C had confirmed there had been no issues with her memory since she had left hospital. This record was a direct contradiction to her evidence and had not been put to her. Accordingly, the Committee approached Person C's evidence with some caution, placing more weight on contemporaneous records, undisputed documents and other undisputed evidence when considering it.

59. In relation to witness VR, who was a part-time qualified Dispenser, in her statement to NHS England dated 3 September 2020, she stated initially there was a lot of chaos in the Pharmacy, it was quite busy but slowly they got to grips with things and the Registrant "*seemed alright*".

60. In her evidence, VR stated that when Person C joined the Pharmacy the three of them had got on quite well although it was "*a bit chaotic"*. She said that Person C was a good dispenser, she *"picked things up quickly"* and VR had been happy to help her, assisting with dispensing and Patient Medication Record ("PMR") queries.

61. VR said that she had never heard the Registrant speak on the phone in another language. She said she had discussed salary levels with Person C, which she said Person C had reported to the Registrant "*behind my back",* and the Registrant had not been pleased they had been having such discussions. VR said there had been "*a bit of an atmosphere*" and she had made her mind up to leave after the Registrant had spoken to her in the consultation room using *"a load of expletives"*. She confirmed she had been suffering from health issues at the time she left the Pharmacy PRIVATE, so her mind was on more important matters at the time.

62. VR left the Pharmacy at the old premises in November 2018 on bad terms with both the Registrant and Person C. There had been an argument between the three of them. It was pertinent that VR and Person C had not kept in contact for several months after VR left and it was only when Person C also left the Pharmacy that Person C had "*reached out*" to VR to discuss the investigation into the Registrant. Initially VR said she had not spoken to Person C on the phone after Person C left the Pharmacy but later in her evidence, she recalled Person C had phoned her. In her witness statement dated 29 April 2023, VR said Person C had contacted her six months after she left the Pharmacy but during her evidence, she said it had been a couple of months later.

63. On cross-examination, VR accepted, when shown Patient 8's PMR, that she had been incorrect when claiming he had received certain medications, including CDs which his records showed he had never been prescribed. The Committee found VR's evidence to be limited in that most of the alleged incidents took place after she left the Pharmacy. She was able to describe some of the Registrant's ways of working during the period she worked with him. It was clear that she had been unhappy with the Registrant and Person C when she left.

64. The Committee heard lengthy evidence from the Registrant over two days. He had come to the UK from Iraq in April 1999 and had not spoken English at that time. He joined High School and worked hard to successfully complete his GCSEs and A levels.

65. The Registrant explained that after qualifying as a Pharmacist in 2016, he had only worked as a locum pharmacist mainly for Allied Pharmacies who were the previous

owners of the Pharmacy. Allied had purchased the Pharmacy on 1 February 2018 and had agreed with the Registrant's brothers, who were not pharmacists, to sell it to them. The sale took place on 1 June 2018 and it was agreed the Registrant would be in charge of running the Pharmacy. He became a joint shareholder and director with his brothers, one of whom had provided most of the purchase funds. The Registrant became the SI and nominated RP. He described the Pharmacy, which at that time was at the old premises, as *"a very small, very badly run shop in a corner unit. It was very old and tired."* The Pharmacy was purchased with a plan to relocate it as it was not viable in the old premises location. The Registrant stated that as soon as the purchase took place, they had started to look for vacant premises to relocate to and the Pharmacy moved to the new premises on 15 February 2019.

66. In his evidence, the Registrant stated that as a locum he had been mainly checking prescriptions, helping the managers and usually there would be another pharmacist present. He said that his brothers had been interested in the pharmacy business and that his own knowledge of what the role of a SI and RP had been was based on what he had observed as a locum. He had never hired staff before.

67. In his evidence, when describing the Pharmacy, the Registrant said "*the whole thing was disorganised"* and he mentioned the word "*chaotic"* several times. He said it had been a stressful time.

68. The Registrant stated that he had PRIVATE, a health condition. He had only become aware of this when he had failed his pre-registration exam as he had found he did not have enough time to complete the test. After he had failed, he had had a private test done which had diagnosed the condition. The Registrant stated that due to his medical condition, he did have difficulties with paperwork and keeping track of things.

69. The Registrant was asked about his relationship with Person C and VR. He said that Person C seemed mature and they became more friendly over time. He said "*the whole setting became too friendly"*. He said that Person C and VR had been discussing him in the Pharmacy and Person C had told him VR didn't like him

speaking on the phone in another language. He denied ever shouting or swearing at either of them.

70. The Registrant said he had felt "*betrayed"* when Person C left as he had spent a year training her and she gave no explanation for leaving. The Registrant said that Person C had not wanted him to fire Person A, who he felt had no interest in the Pharmacy. Person C had questioned him about who he was interviewing. He said that Person C did not like it when he asked her why she was questioning him all the time, and that she had to let him make the decision. The Registrant felt that Person C and Person A had got too close towards the end. Person A did not show up at work after he told Person C he intended to fire Person A. He said that Person C was getting too involved in how he was recruiting people and he thought she had left because he said he wanted to be in charge. He said that Person C got angry, said she was not well and then didn't show up at work again.

71. The Committee had no doubt that the Registrant was completely out of his depth with agreeing to run the Pharmacy. He had qualified in August 2016, worked as a locum pharmacist and 22 months later became a business owner, SI and RP without any additional training. His only learning was watching others while he was a locum. He had taken on far too much at an early stage of his career with no real understanding of the responsibilities of the roles of RP and SI. He had been a poor manager, with little experience of managing any staff, let alone managing a Pharmacy business. He did not have the business acumen or skillset required to take on such a venture and manage it competently. The language used and the nature of the WhatsApp messages were an indication of his lack of professionalism and immaturity. There was no doubt that this had been a chaotic pharmacy, and the lack of organisation was further exacerbated by a relocation within 8 months.

Allegation 1

1. ***On one or more of the dates indicated in Schedule A you caused or allowed the following to be supplied or sold while there was no pharmacist on the premises:***

    1.1 Controlled Drugs,
    1.2 Prescription-only medicines other than Controlled Drugs,
    1.3 Pharmacy medicines;

72. The Committee heard a great deal of evidence in relation to this Allegation which was pleaded on the basis that no pharmacist had been on the premises when the Registrant was alleged to have caused or allowed the supply of medications on 70 occasions listed in Schedule A, each of which were alleged to have taken place by the use of WhatsApp messages. The parties had agreed in their Agreed Facts Statement that the medicines listed at Items 43 (Nicotine) and 64 (Sodium bicarbonate) did not require a pharmacist to be present when they were supplied to patients so the Committee did not consider these any further and they were not proved.

73. The Council alleged the Registrant had been absent from the Pharmacy for lengthy periods of time during the working day, whereas the Registrant denied this had been the case.

74. Person C had alleged in her witness statement that the Registrant was regularly away from the Pharmacy at the old premises "*for a couple of hours*" and left her alone in the Pharmacy. She alleged that at the new premises, he was absent *"for long periods of time… usually for two or more hours a day…".* In her evidence, she said that she had not been aware at the time that the Registrant could be absent from the Pharmacy for up to two hours but said he was away for longer than that anyway. She accepted there were occasions when the Registrant was absent from the Pharmacy for 20-30 minutes but said there were times when he was away longer. She agreed he took phone calls "*all over the Pharmacy"*, that he did go to the petrol station across the road and the bakery next door. She was not aware that he smoked.

75. Person C stated that if a locum pharmacist was working and the Registrant was in the shop but not on the shop floor, she would ask the locum pharmacist to check prescriptions. She confirmed she often saw Pharmacist 1, the Registrant's sister, working at the Pharmacy, particularly at the new premises. She confirmed that another locum pharmacist called "Ishy" had worked there maybe twice but not regularly and there was also another locum who had worked there. The Committee noted this was supported by the contemporaneous locum invoices provided.

76. Person C said that there was not a significant number of times when both the Registrant and a locum pharmacist were in the Pharmacy, perhaps a handful of times and only one of them would be working.

77. In her witness statement Person C confirmed that she had created the WhatsApp group with her, the Registrant and Person A on 24 March 2019. It had been created as a means for them to easily communicate and provide a space for the new employee Person A to ask questions. On cross-examination she could not remember if she had created the group but accepted that she had thought it was a good idea to create it as part of training. She said that whilst the WhatsApp group had started as training, it had drifted into sending photographs of medicines to give out to patients.

78. Person C said she had sent photographs of medications by WhatsApp to the Registrant to check and said that she had been aware that a pharmacist had to "*OK it"* before she could give these to patients, although she had not known the pharmacist should be there in person to do the final check. She said there had been occasions when she had sent a photograph to him and he authorised her to give the medication to a patient. She stated that photographs were only sent to the Registrant when he was not in the Pharmacy building and he was never in the Pharmacy when messages had been sent. She accepted that she had known it was wrong to give patients medicines without the Registrant or another pharmacist being on the premises but said that she was "*just following instructions from my manager"*.

79. VR gave some evidence about the amount of time the Registrant was absent from the Pharmacy at the old premises. She said that he would be away for 20-30 minutes at times and she recalled he was on the brink of buying new premises so he would go to the other shop. She said she had called him once or twice on his phone and he came back to the Pharmacy. She said that he would often spend "*too long*" in the toilet and she had phoned him on a few occasions when he had been in there as he had told her to. She said that he would *"nip out"* at the back of the Pharmacy sometimes. He would also take his prayer mat into the consultation room to pray and she would not call him while he was praying.

80. In his witness statement, the Registrant said that the WhatsApp group was set up because Person C and Person A kept asking him the same questions at different times. He said that Person C thought it would be a good idea to set up the WhatsApp group for training. He stated that the way in which this WhatsApp group was used changed over time.

81. The Registrant was cross-examined at length about the WhatsApp messages and his absences from the Pharmacy. His response to many of the questions was that he could not remember. He was unable to recall the specifics of the conversations on WhatsApp, or where he may have been at the time they were sent, or how long he may have been absent/unavailable.

82. In his interview with the NHS Counter Fraud Authority on 28 April 2021, he had said he popped out of the Pharmacy for 5 or 10 minutes, but in his witness statement dated 3 May 2024 he stated it had been no more than an hour. On cross-examination, the Registrant said he had been very stressed at the time of his interview on 28 April 2021 and could not remember the full conversation that had taken place or which premises they related to. He said the old and new premises were less than 10 minutes apart and at the time of the interview, he had thought his absences were 5 to 10 minutes, but it may have been longer. He thought the comment was part of a longer conversation. It was put to him that walking to and from the new premises would have taken around 20 minutes to which he replied "*It was pretty quick".* The Registrant stated he was always in the Pharmacy and did not recall being absent for more than 10 minutes. It was put to him that when he went to KFC, which was mentioned in the WhatsApp messages and which he said was 10 minutes drive away, this would mean he was absent for 20 minutes to get there and back. He then said he didn't think it would be 20 minutes and he couldn't remember "*the specifics*".

83. The Registrant accepted he had not recorded his absences in the RP Log but said that he had not realised that absences of less than 2 hours had to be recorded. He said

that at the time he did not know what "*absences*" were but now he realised he should have logged in and out every time he left the Pharmacy. He said his absences had always been short, saying "*Cale Green was my baby, it doesn't make sense for me to be absent… I wanted to be back as soon as possible".*

84. In relation to the WhatsApp messages, the Registrant said that Person C knew she could not supply medicines to patients without them being checked by a pharmacist first. He said that sending photographs of medicines by WhatsApp had started when he was busy although he could not remember "*the specifics*". He said that pictures would be sent to him when he was on the Pharmacy premises and it had become a bad habit where he was too busy to deal with the dispensary, but wanted to know if the medicines were ready for him to check. He said that in most cases, he would come to the Pharmacy to check the medicines or they would be checked by his sister (Pharmacist 1) or the locum on duty. The Registrant said that he was often in the consultation room, on the phone or in the alley at the back of the Pharmacy smoking. He had not wanted anybody to know that he smoked so he had not told the staff about this.

85. The Registrant stated it was a mistake to allow this to keep happening and it became a normal routine which he now realised was a bad habit. He stated it was a bad practise, which he had very badly managed. He had just gone with the flow due to his naivety. He stated he had developed a bad habit of relying on messages which had initially started with him asking the staff to send him pictures of urgent medications. He said that Person C would prepare the medicines, send him pictures of them as she was still learning, and he made sure they were ready for him to look at before he came to physically check them. He said he had been running the Pharmacy using WhatsApp messages which was not a good way to do things. He accepted he had made mistakes and had been too casual communicating on WhatsApp.

86. The Registrant maintained that there had always been a pharmacist present at the Pharmacy and that as far as he knew, everything was checked, although on reflection

he realised that there may have been some occasions when he was under stress and medicines were supplied using WhatsApp messages.

87. Evidence was also given by Person C and the Registrant about the size of the Pharmacy which it was agreed was not very big. The Committee was shown photographs of the consultation room which, in the new premises, was next to the counter at the front of the Pharmacy. If the Registrant had entered it through the door next to the counter, staff members would have been able to see him.

88. The Committee considered Schedule A in detail and methodically went through each of the remaining 70 items listed (the parties had agreed that Ispagel in item 13 was a 'General Sales List' ("GSL") medication and could be supplied in the absence of a pharmacist). This Allegation had been pleaded on the basis that there was no pharmacist at the premises on the relevant date. The Committee therefore considered each respective WhatsApp message, the Pharmacy RP Log for that day and whether another pharmacist had been working on each of the dates alleged, by reference to locum invoices.

89. The Committee found item 1 (28.01.19 at 11:00), item 2 (29.01.19 at 09:30), item 4 (11.02.19 at 14.24) and item 56 (20.05.19 at 11:19) **not proved** as there was no evidence the Registrant had responded to the photographs of medications sent to him with any message so he had not caused or allowed them to be supplied. The Committee also noted that on 29.01.19, Pharmacist 2 was registered on the RP log as the RP that day.

90. The Committee found item 3 (31.01.19 at 09:16) **not proved**. Whilst the Registrant had replied with "*Yes"*, "*Give*" to the photographs which indicated he had authorised the medicines to be given to patients, there were locum invoices for that day from both Pharmacist 1 and Pharmacist 2 from 9am-6pm indicating two pharmacists were on the premises that day. The Registrant had been registered as the RP that day from 08:45-19:02. The documents showed there were 3 pharmacists on the premises that day.

91. The Committee found item 28 (23.04.19 at 10:09) **not proved**. The WhatsApp messages showed photographs being sent by Person A for Fexofenadine and Avamys with messages from Person A saying "*Emergency supply… Waiting for ex ...Rx"* which indicated there was no prescription for these items yet. There was no photograph of the prescription. The Registrant replied "*Okay"* but it was not clear whether he was agreeing to waiting for the prescription or allowing the supply to the patient. The comment could be interpreted either way and the context of these messages was not known. The Committee concluded the Council had not discharged the burden of proof on this item.

92. The Committee found item 67 (22.05.19 at 15:17) and item 68 (22.05.19 at 15:37) **not proved** as the date these photographs were sent was on 24.05.19 not 22.05.19 as pleaded. There was no item on Schedule A for 24.05.19. Accordingly the Council had not proved the Registrant had caused or allowed those medications to be supplied on 22.05.19.

93. The Committee found item 60 (20.05.19 at 18:03-05) **not proved**. Although there was a locum pharmacist working on this date, that pharmacist had finished work at 6pm as shown on the locum invoice. The Committee therefore concluded that there was no pharmacist on the premises after 6pm. Pictures of a Methadone prescription, Methadone poured into a measuring cylinder and a labelled bottle were sent to the Registrant at 18:03, 18:04 and 18:05 by both Person A and Person C, the Registrant had initially replied saying "*yes"* at 18:03*, "yeah"* at 18:04 and *"yes"* at 18:05 but at 18:07 he had replied: "*If she's not due, don't give plz", "She's not due", "Is she due?"*. Person C had replied at 18:07 confirming the medication was not due that day and at 18:08 the Registrant replied *"Do not give".* At 18:10 the Registrant replied "*Just say Mahmoud said no"*. The Committee was satisfied that on this occasion, the Registrant had not caused or allowed the supply of this item while there was no pharmacist on the premises as he clearly and unequivocally told Person C not to give it to the patient having realised the medication was not due that day.

94. On the other instances when a picture of medications had been sent by WhatsApp to the Registrant, he replied within seconds or within a few minutes stating simply "Yes", "Yeah", "Okay give", "Okay", "Good to go", "Yesss", "Yeahh", "*Yeah that's fine*" and "*Lol yes"*. The final comment, "*Lol yes"* had been made by the Registrant on 04.06.19 at 10:23 when Person C had sent a photograph with medication at 10:22 accompanied with the message: "*Hello I believe you are dying… But am I good to give this out".* The Committee was satisfied this and the other comments listed were an instruction from the Registrant to whoever had sent the photograph, Person C or Person A, to supply the medicines to patients.

95. The Registrant had stated in his evidence that on most of the occasions these photographs had been sent to him, he had been at the Pharmacy premises. He said that he had asked Persons A and C to get the medications ready and then send him a photograph of them to let him know that they were ready for him to check in person. He accepted there may have been a few rare occasions when photographs were sent to him when he was not on the premises. Both Person C and the Registrant had been consistent in saying that the WhatsApp group had initially been created as a form of training and then it had developed into something else. The Committee noted that the Registrant had rarely asked questions on WhatsApp in response to photographs sent to him, before approving the supply to the patient within seconds or minutes. This suggested that he was not in the Pharmacy to check these matters himself, rather than demonstrating that he was training his staff. An example was on 29.03.19 when he asked Person C to *"Check …. Expiry of gum"* something he could have done himself if he was in the Pharmacy checking medication in person before it was given to patients.

96. This was a relatively small pharmacy with only 2 or 3 members of staff when there was no locum pharmacist. Whilst some of the WhatsApp messages had been used as informal communication between work colleagues at times, there was little evidence in this case that the sending and approving photographs of medications had been used for training purposes, either while the Registrant was in or away from the Pharmacy on the material dates. It was not plausible that if the Registrant had been

in the Pharmacy, Person C would not simply show him the medication but instead she would spend time taking photographs and sending them to him only to repeat the exercise by physically showing the medication to him when the Registrant appeared from whatever he was doing. There were few photographs sent to him on WhatsApp while he appeared to be in the Pharmacy. It was also relevant that there were gaps in the day when no photographs of medications were sent which was an indication that the Registrant was likely to be in the Pharmacy during those times checking in person before medications were given to patients.

97. The Committee determined it was more likely than not that the Registrant had been absent from the premises for the majority of the dates that the photographs had been sent. Whilst it was not necessary for the Committee to make a finding on how long the Registrant had been absent from the Pharmacy on each occasion, the Committee was satisfied that this varied from 20 - 30 mins and on a few occasions was no more than one hour based on the time lapses between the contemporaneous WhatsApp photographs, messages sent and the Registrant's own admission. The Committee then considered, for the purposes of Allegation 1, whether there was a pharmacist on the premises on each of the relevant dates.

98. Mr Geering had raised an issue concerning Pharmacist 1, the Registrant's sister. There were 3 dates (21 and 22 May 2019 and 4 July 2019) when she had provided locum invoices stating she had been working all day at the Pharmacy but on these dates, she was also registered as the Responsible Pharmacist at another pharmacy at the same times. Mr Geering submitted she could not have been in two places at once and that no weight should be placed on any of her locum invoices. The Committee accepted that the invoices for these particular dates could not be relied upon but did not accept that all of her locum invoices should be disregarded. There was evidence from Person C that Pharmacist 1 regularly worked at the new premises. Pharmacist 1 had not been called to give evidence. It was possible an error had been made on these particular three dates – Pharmacist 1 could have been at either pharmacy, indeed she could have spent some time at both pharmacies on those dates but there was nothing to suggest there was an issue with her other invoices. It

was also pertinent that her other invoices did not cover every date in Schedule A which suggested it was more likely than not that she had worked on the dates claimed save for the disputed 3 days where there was evidence she may have also worked elsewhere. There was no allegation concerning 4 July 2019 in any event. Accordingly, the Committee disregarded her invoices for 21 and 22 May 2019 but accepted the remaining locum invoices as evidence that she had worked at the Pharmacy on the dates and times stated.

99. The Committee carefully considered each of the WhatsApp messages relied upon, the photographs provided, the response given by the Registrant and whether there was a pharmacist on the premises at the relevant time. The photographs started being sent by WhatsApp on 28 January 2019 and continued until 14 June 2019 around the time Person C left.

100. Whilst Person C had said that she only ever sent photographs of medications to the Registrant when either he was not on the premises or there was no other pharmacist on the premises, the Committee noted there was evidence to suggest this had not always been the case as follows:

- On 29/1/19 at 09:30, Person C had sent a photograph of medication when Pharmacist 2 was registered as the RP.
- On 27/3/19 Person C sent photographs of medication to the Registrant at 09:06 when he appeared to be in the Pharmacy, possibly on the lavatory. The Registrant was asked to see a patient and said no, telling Person C *"I can't come out now…. Say he's out ….. Come back later …. What did you say?.... I was shitting or out"*. Person C replied *"I said you were here but unavailable"*.
- On 9/5/19 at 12:57, Person C had sent photographs of medicines to the Registrant while Pharmacist 2 was the locum on duty.
- On 10/5/19, messages were sent to the Registrant by Person C while a locum was on duty with a query at the locum's request.

- On 04.06.19 at 10:22, Person C had sent photographs of medication to the Registrant when it appeared he was not well and Pharmacist 2 was the locum and RP on that date.

101. No evidence had been given by the relevant locums. The contemporaneous records indicated the locums were working at the Pharmacy on a number of dates on Schedule A. It was not clear why Person C had not asked the locum on duty to check the medicines, what that locum was doing at the material time, and why Person C had not waited until the locum became available, or where that locum may have been. Nor was it clear why Person C was sending photographs and messages to the Registrant when a locum was on duty. The burden of proof was on the Council and the Committee concluded that the Council had not shown that it was more likely than not that a locum pharmacist was not working at the Pharmacy on the dates given on the locum invoices (save for 21 and 22 May 2019 as set out above).

102. The Committee therefore found the following items on Schedule A **not proved** as either the Registrant was not the registered RP on the respective date and/or a locum invoice had been provided which confirmed another pharmacist was on the premises on the respective date. The Council had not proved that there was no pharmacist present on the premises at the material times on the following dates:

- Items 5 and 6 - 25.03.19
- Items 7, 8, 9, 10 and 11 - 26.03.19
- Item 24 - 09.04.19
- Item 25 - 11.04.19
- Items 27 - 23.04.19
- Item 29 – 24.04.19
- Items 30 and 31 – 25.04.19
- Items 32 and 33 – 26.04.19
- Items 34 and 35 – 29.04.19
- Items 36 and 37 – 01.05.19
- Items 38 and 39 – 02.05.19

- Item 40 – 07.05.19
- Item 41 – 09.05.19
- Items 42, 44, 45, 46, 47 and 48 – 13.05.19
- Item 49 – 14.05.19
- Item 50 – 16.05.19
- Items 51 and 52 – 17.05.19
- Items 53, 54, 55, 57, 58 and 59 – 20.05.19
- Item 69 – 28.05.19
- Item 70 – 04.06.19 (Pharmacist 1 was the registered RP)
- Items 71 and 72 – 14.06.19

103. The Committee then went on to consider the remaining items on Schedule A where locum invoices had not been provided and there was no evidence of another pharmacist being on the premises on the relevant dates. These were as follows:

    - Items 12 and 13 - 27.03.19 (but not Ispagel as agreed by the parties)
    - Items 14 and 15 – 28.03.19
    - Items 16, 17 and 18 – 29.03.19
    - Items 19, 20, 21 and 22 – 02.04.19
    - Item 23 – 08.04.19
    - Item 26 – 18.04.19
    - Items 61, 62 and 63 – 21.05.19
    - Items 65 and 66 – 22.05.19

104. The Committee was mindful that although it had found a number of items on Schedule A not proved because a locum pharmacist was working at the Pharmacy on the relevant date, there was also evidence in the contemporaneous WhatsApp messages suggesting the Registrant had not been on the premises on the dates and times when photographs were sent and replied to. Examples were as follows:

    - On 26.03.19, the Registrant had approved medications by WhatsApp at 11:24 and was asked by Person C at 11:28 *"Can you pick up pizza on your travels?*

Will pay when you get back". On the same date at 17:00 when approving a few medications he stated "*Top one might be in fridge*" which implied he was not there.

- On 25.04.19, the Registrant is told by Person C that a lady does not want to wait for fluoxetine to which he replies "*Okay show me"* before approving the supply with *"Okay … Yeah"*.
- On 26.04.19, Person A sends a photograph with medication followed by the message *"doesn't want to wait"* to which the Registrant replies "*Okay"*.
- On 01.05.19, the Registrant approves the supply of medication at 11:59 and is told at 12:00 by Person C "*Mahmoud I need to go"* to which he replied at 12:01 *"I am on way back …. Go".*
- On 20.05.19, at 17:43, the Registrant was sent a photograph of medications to which he said *"yes"* and 10 minutes later he was asked to collect a prescription from a patient. His reply at 17:53 was *"I'm too far now …. Have meeting"* which indicated he was more likely than not away from the Pharmacy when the first message was sent. He was being sent photographs of other medication at this time too. The Registrant asserted in his evidence that he was sure he did not have a meeting that day, but he was unable to recall details surrounding other WhatsApp messages so the Committee found it difficult to accept he remembered this one so clearly.

105. Taking into account that a number of messages had been sent to the Registrant when he was not at the Pharmacy but another pharmacist was, the Committee concluded that it was more likely than not that the Registrant was not at the Pharmacy when the remaining messages were sent to him and therefore there was no pharmacist on the premises on the remaining dates. In the absence of any evidence of another pharmacist working, it was reasonable to assume that the Registrant had been the only pharmacist on duty. It was notable that there were gaps throughout each day where no WhatsApp messages were sent so it could be inferred from this that he had been in the Pharmacy during those times. The Committee found as follows:

- Items 12 and 13 - 27.03.19 at 10:08 and at 16:29 – **Proved.** It was more likely than not that the Registrant was not on the Pharmacy premises at these times.
- Items 14 and 15 – 28.03.19 at 11.24 and at 13:44 – **Proved.** It was more likely than not that the Registrant was not on the Pharmacy premises at 11:24. At 13:43 the Registrant replied "*Say he's popped out for* lunch" in response to Person C who informed him that a patient wanted to see him. It was clear that Person C did not know where the Registrant was as she asked him at 13:44 "*Are you next door"*. It was more likely than not that he had gone out for lunch at that time.
- Items 16, 17 and 18 – 29.03.19 at 15:45, 15:51 and 16:07 – **Proved**. These messages had been sent close to each other. At 15:51, the Registrant replied to the second photograph *"Check…. Expiry of gum"*. It was more likely than not that he was not in the Pharmacy to check it himself.
- Items 19, 20, 21 and 22 – 02.04.19 at 08:48, 12:10. 14:40/41 and 14:47 – **Proved Items 19 and 20.** The Registrant was more likely than not to have been absent from the premises at 08:48 and 12:10, particularly as this was early in the morning and over lunchtime.

  Not proved Items 21 and 22. At 14:40 Person C sent a message and a photograph to the Registrant asking "*Where you gone"* which indicated she did not know where he was. He replied "*Toilet"* and then asked to see the prescription and label for the medication. The Committee accepted it was more likely than not to have been the Pharmacy toilet and that the Registrant was on the premises at the material time.
- Item 23 – 08.04.19 at 13:42 – **Proved**. It was more likely than not that the Registrant was not on the Pharmacy premises at this time especially as it was over lunchtime.
- Item 26 – 18.04.19 at 12:53 – **Proved.** It was more likely than not that the Registrant was not on the Pharmacy premises at this time especially as it was over lunchtime.

- Items 61, 62 and 63 – 21.05.19 at 11:21, 15:12 and 16:35 – **Proved.** The Committee had already disregarded the invoices from Pharmacist 1 as the documents showed that she appeared to have been working at another pharmacy on this day too. It was more likely than not that the Registrant was not on the Pharmacy premises at these times.
- Items 65 and 66 – 22.05.19 at 10:18 and 14:54 – **Proved.** The Committee had already disregarded the invoices from Pharmacist 1 as the documents showed that she appeared to have been working at another pharmacy on this day too. It was more likely than not that the Registrant was not on the Pharmacy premises at these times. At 14:23 Person C had sent him a WhatsApp message asking him how to work the fridge as it was beeping which indicated the Registrant was not on the premises. He was sent a photograph of medication about half an hour later from which it could be inferred that he had not returned.

106. **The Committee found Allegation 1 proved but only in relation to Items 12, 13, 14, 15, 16, 17, 18, 19, 20, 23, 26, 61, 62, 63, 65 and 66 on Schedule A.**

Allegation 2

2 With regard to Allegation 1:

2.1 on one or more occasions you failed to supervise the supply or sale of the products adequately in that you used an electronic messaging system to check the medication and/or to instruct the supply or sale of the items while you were not on the premises.

107. The Committee considered the Items on Schedule A which it had found proved and whether on each of those occasions the Registrant had failed to supervise adequately the supply or sale of those items by using Whatsapp and/or he had instructed the supply or sale while he was not on the premises. These were Items 12, 13, 14, 15, 16, 17, 18, 19, 20, 23, 26, 61, 62, 63, 65 and 66 on Schedule A. The Committee had already found that it was more likely than not that the Registrant had been away from the premises on each of these occasions and had set out why in its reasoning under Allegation 1. The Committee also considered Items 21 and 22 on

Schedule A which the Registrant had approved for supply to the patient on 02.04.19 while the Registrant appeared to be on the toilet at the Pharmacy premises.

108. The Registrant himself had accepted that it was possible there may have been rare occasions when he had agreed to supply medications to patients while he was not at the Pharmacy but that had not been his intention.

109. The Committee considered the Guidance document provided by Mr Geering and noted the definition of supervision from The Royal Pharmaceutical Society Guidance on Responsible Pharmacist stated as follows: *"supervision requires physical presence and pharmacist being able to give advice and intervene."* Mr Geering had also referred the Committee to Razzak v GPhC [2016] EWHC 1204 which stated:

> "*the responsible pharmacist must be present in the pharmacy to supervise the sale or supply of prescription-only medicines and in addition, he or she must be in a position to give advice and intervene in connection with the sale or supply of prescription-only medicines."*

110. The Committee did not consider approving the supply of Controlled Drugs ("CDs"), prescription-only medicines other than CDs medications or pharmacy medicines by using photographs and messages on WhatsApp to be an adequate form of training or supervision, especially when the Registrant was not in the Pharmacy. There was no evidence that the Registrant had checked the PMR, or the medication inside the boxes in the photographs, or in some cases the labels on the medicines. The Committee had found a number of occasions when the Registrant had approved the supply of medications by WhatsApp when he had not been on the premises and this was not an adequate form of supervision. He had not been there in person to give advice to the patient or to his staff, or to intervene if required.

111. There had been one occasion on 02.04.19 when the Registrant had been on the premises and appeared to be in the lavatory when approving the supply of medication to a patient using WhatsApp photographs. The Committee was satisfied

this was not adequate supervision. Again, there was no check of the PMR, or what was inside the medication boxes. It would have been more appropriate for him to have told Person C to wait for him to come out. Whilst the Registrant was on the Pharmacy premises, he had not made himself available to give advice and intervene if required.

112. **The Committee found Allegation 2 proved in relation to Items 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 26, 61, 62, 63, 65 and 66 on Schedule A.**

Allegation 3

3. On one or more occasions on dates unknown you:
3.1 caused or allowed patients to be supplied with, and take home, medication requiring supervised consumption.

113. During the course of his evidence, the Registrant admitted that he had allowed one patient to take home Buprenorphine medication. He confirmed that this had been the patient's first dose and it had been at the start of Ramadan when the patient was fasting. The Registrant stated that the patient came in at the last minute towards the close of the Pharmacy and at the time the Registrant had thought it was in the best interests of the patient to make that decision for him as the patient was agitated. He said he had thought the patient would do more harm if he didn't take the medication with him. He had advised the patient to go back to his supplier and get the prescription changed which the patient had agreed to do. The Registrant confirmed that he now realised this had been a bad idea and he should have contacted the prescriber to get the prescription adjusted. The Registrant stated he had never allowed this to happen again, he understood the consequences and he appreciated that he must act according to the rules. The Committee found this Allegation proved on the Registrant's admission. He had allowed a patient to take home a prescribed medication, which was a CD requiring supervised consumption.

114. **The Committee found Allegation 3 <u>proved</u>**.

Allegation 4

4. You failed to ensure safe custody of Controlled Drugs in that you did not adequately control access to the keys for the Controlled Drugs cabinet.

115. Person C's evidence was that there was no safe in the Pharmacy in either the new or the old premises, only a CD Cabinet to which she said she had a key at the new premises. She said this key was on her set of keys which allowed her in and out of the Pharmacy. She described where the CD Cabinet was in both the old and the new premises but maintained there was no safe at either premises. She also alleged Person A had been given a CD Cabinet key in the new premises.

116. VR had stated that there had been one safe and one CD Cabinet at the old premises. She said that the key for the CD Cabinet was kept in the safe overnight and during the day it was in the lock in the CD Cabinet. She said that the key was usually kept with the pharmacist and if she needed anything from the CD Cabinet, she would have to request the CD Cabinet key. She stated nobody else had keys to the CD Cabinet.

117. The Registrant gave evidence stating that the keys to the CD Cabinet were always kept in the safe at the Pharmacy. He accepted that his staff had keys to the safe which would give them access to the CD Cabinet key and that should not have happened. He appreciated that the safe key should not be with a staff member if the CD Cabinet key was stored in the safe. The Registrant stated that he had not intentionally allowed Person C to access the CD Cabinet and accepted that he had potentially failed to safeguard CDs. He said it would never happen again.

118. The Committee had been provided with evidence of one occasion on 20.05.19 at 18:03 when Person C had taken photographs of Methadone and sent them by photographs on WhatsApp to the Registrant. The Registrant could not remember this specific incident but thought he may have allowed Patient C to start dispensing and he then popped out for a smoke. He said that he would only have allowed her to dispense under his supervision. This was also the incident where the Registrant stated that he had not had a meeting and said at 17:53 "*I am too far now*". As the Registrant could not remember the detail of this dispensing, the Committee could

not rely on his recollection that he had not had a meeting. It had already found that the Registrant was more likely than not away from the Pharmacy when this incident took place. Accordingly, there was evidence that Person C had had access to the CD Cabinet when he was not on the premises on that date.

119. The Committee was therefore satisfied that there had been at least one occasion when the Registrant had failed to ensure the safe custody of CDs and had not adequately controlled access to the keys to the CD Cabinet.

120. **The Committee found Allegation 4 <u>proved</u>**.

Particular 5

5. On the occasion in Schedule B you claimed payment for an item which had not been supplied.

121. This Allegation concerned the Penalty Charge Notice dated 21 May 2019 which had been issued to Person C's previous boyfriend JR. He had been a patient of the Pharmacy and had had a Pre-Payment Certificate for his prescriptions. His medication had been dealt with by Person C.

122. Person C had described how she had got the medication ready for JR, she said she signed the exemption herself, bagged it up and phoned JR to tell him it was ready for her to bring home. She said that JR told her he did not need the medication so she had given the prescription to the Registrant, taken the medication out of the bag and placed it back on the shelf. She said that she gave the prescription to the Registrant to deal with and informed him that JR no longer wanted it. She said that she had only found out JR's Prepayment Certificate had expired after JR received the Penalty Charge Notice *"a week or two later*". Person C said that as this had been an electronic prescription, it could not be shredded, as it had already been scanned and it was the Registrant's job to deal with it.

123. There were a few inconsistencies in Person C's evidence and her witness statement. In her statement she had stated that JR had informed her he no longer had pre-payment for his prescriptions and that she had told the Registrant this. She also said in her statement that she gave the labelled medication to the Registrant. When asked about this, she said that the Registrant had given her the medication back to put away and he had dealt with the paperwork. On further questioning Person C said that they had agreed the Registrant would deal with prescriptions which were not dispensed as she did not know what to do with them. When asked how the claim could have gone through, Person C said that she had ticked the exemption box when scanning the electronic prescription in response to a prompt on the computer and she could not remember if the prescription had been changed when she found out his pre-payment certificate had expired. She said the prescription was put in a pile in a category and the Registrant had claimed for it.

124. The Registrant did not recollect being told about JR's prescription or remember this specific prescription. He said that he did not usually take prescriptions back. They simply got filed to be claimed, or if they were no longer required, they were shredded if just one item was on the prescription, or returned to the online computer *"spine*" if there was more than one item, so that if the patient changed their mind later it could be accessed by other medical professionals. The Registrant said that Person C had always dealt with JR's medication, she ordered his prescriptions, and when they were ready, she would put the medication in her bag and file away the prescription in the relevant category. He thought she may have taken JR's medication and forgotten to take the prescription out of the relevant basket. He said he would never have claimed for JR's, or anyone else's prescription, in such circumstances. He confirmed the cost of the inhaler which this prescription related to was about £2-£3, possibly even only 50p if it was a generic medicine.

125. The Registrant was asked why he had agreed to pay for the Penalty Charge Notice. He said that Person C had come to him distressed, crying and upset saying that her boyfriend had got a penalty charge. He said he had not known what the penalty charge was for. She had been his first employee, he said he was new to all of this

and he had been too nice. He said time had been very precious to him due to the relocation of the Pharmacy and this had not been a big deal. He said he did not see it as a problem to pay someone, and Person C *"was different and had helped me a lot"…. I thought I would help her"*. He said that was his character – he did not see it as a problem if someone asked him for £100. He would do this for anybody if they had not done anything wrong.

126. The Committee noted there was agreement between both Person C and the Registrant that after a prescription had been dispensed, it would be placed in categorised piles in one of the relevant coloured mini baskets ready to be claimed at the end of the month. The Penalty Charge Notice was dated 21 May 2019 and related to a claim that had been made between 3 December 2018 and 5 March 2019. JR could not have therefore received it within a couple of weeks of this incident and Person C must have been mistaken about this.

127. The Committee concluded that there had been an error in the process and procedure when this claim was submitted. Both Person C and the Registrant thought the other person had dealt with the prescription. The value of this prescription seemed to be very low although from the Penalty Charge Notice it appeared there had been two items on the prescription rather than one, as the Notice confirmed the correct prescription charges should have been £17.60. The NHS Counter Fraud Authority Interview had also referred to two items. No information had been provided about the possible value of the other item and Person C had only mentioned one inhaler when discussing the prescription.

128. The exact date this claim had been made was not known but it was on a date between 3 December 2018 and 5 March 2019, which all the witnesses had agreed was a busy and chaotic time at the Pharmacy due to the relocation. The prescription itself had not been provided. It appeared that the computer system had a record that it had been dispensed and this was not changed. The RP Log and the locum invoices showed that during this period there were many dates when locum pharmacists had also been working at the Pharmacy.

129. The Committee concluded that it was more likely than not that the prescription had inadvertently ended up in a pile of prescriptions to be submitted at the end of the month and nobody had checked or corrected it. It had more likely than not slipped through in all the chaos of the relocation. The Committee was satisfied that the Registrant had not known the claim had been made and it accepted his explanation that he had paid the £100 to Person C as a gesture of friendship to help and support her as a valued employee. It was highly unlikely he would deliberately submit a fraudulent claim for only one prescription of a low value. However, a claim had been made for an item which had not been supplied to the patient, albeit in error. As the SI he was ultimately responsible for ensuring accurate claims were submitted. The Committee found Allegation 5 proved on that basis.

130. **The Committee found Allegation 5 <u>proved</u>**.

Allegation 6

6. Your actions as set out in Allegation 5 above were dishonest in that you knew the item had not been supplied to the patient.

131. The Committee had already found that this claim had been made in error without the Registrant's knowledge and Allegation 5 had been proved as responsibility for accurate claims rested with the Registrant as the SP. The Committee applied the test in <u>Ivey v Genting Casinos</u> when assessing whether the Registrant had acted dishonestly. He denied he had and said he would never have claimed for this or any prescription that he was not entitled to. The Committee was satisfied that the Registrant had not known this particular prescription had been submitted when the medication had not been supplied to JR. He had not known that JR did not want his prescription, indeed he had never dealt with JR. The Committee was satisfied that the Registrant's conduct would not be regarded as dishonest by the standards of ordinary decent people as he had not deliberately submitted a claim for a prescription that had not been supplied.

132. **The Committee found Allegation 6 not proved.**

Allegation 7

7. On one or more of the occasions set out in Schedule C, you created, or caused to be created, fraudulent Medicine Use Reviews ("MURs") in that a review had not been undertaken.

133. There were 18 Medicine Use Reviews ("MURs") listed on Schedule C which were alleged to have been fraudulently created. The Council's case was that these MURs had not taken place at all.

134. Witness A, who at the time was the Senior Primary Care Manager for the NHS England Team in Greater Manchester, gave evidence to confirm that MURs were an NHS commissioned Advanced Pharmacy Service which should be conducted at pharmacy premises. A patient was required to consent to a MUR and this would normally be done with a written Consent Form. The MUR would then be undertaken by a pharmacist with the patient in a consultation room. Witness A stated that either the pharmacist could use a template to complete the MUR, or write their own to capture key aspects of the review. He confirmed that patients were usually selected by pharmacies according to their medications or medical conditions, but this was at the discretion of the pharmacy. He confirmed that a MUR on a patient would take place annually and would only be more frequent if there had been a significant change in medication or a specific clinical need.

135. Witness A confirmed that the Pharmacy had provided a number of Consent Forms and a MUR Summary Report which confirmed what MURs had been claimed for payment. He stated that there were Consent Forms missing for some of the patients where a MUR had been claimed. He also confirmed that MURs were carried out mainly by the Registrant and Pharmacist 1, his sister. He confirmed on cross-examination that if a MUR took place on a particular date and the PMR record was amended, the amendment would still be shown as an entry on the system.

136. Person C gave evidence that she did not know what MURs were at the time she worked in the Pharmacy but she had been told to ask patients, when they collected

their prescriptions if they had any concerns with their medications. If they were happy to do so, she asked them to sign a Consent Form which had been stapled to their medication bag awaiting collection. She stated that Pharmacist 1, the Registrant's sister, had instructed her to ask patients to sign the forms which were stapled to the medication bag. She said she was told the Pharmacy would get a bonus depending on how many forms were completed. She said that she had not known what a MUR was so had not explained it to the patient, she had not been making any assessment and did not know the full process involved. When shown a MUR document she said she had never seen such a document before.

137. The Committee concluded from Person C's evidence that she did not know the difference between a Consent Form and a MUR. She thought the review had been conducted by her asking patients if they had any issues with their medications and getting them to sign the form stapled to the medication bag, which was a Consent Form. Her evidence was therefore of limited assistance.

138. The Committee considered each of the MURs in turn.

Items 1-4 – Patients 1, 2, 3 and 4

139. Patients 1 to 4 were living in a care home and lacked mental capacity to make certain decisions. Consent Forms had been provided for all 4 Patients. The date on one of the Consent Forms was clearly an error in that it referred to 2011 instead of 2018 and both parties accepted this. Each of the Consent Forms had been signed, on behalf of the patient, by JD, who had been a Support Worker at the care home at the material time. She had not been called to give evidence. The Registrant had provided copies of the MUR Forms for all 4 patients which were each dated the same date as the respective Consent Forms.

140. The Committee heard evidence from Witness B, who was a Support Worker at the care home and from Witness C who had been the Service Manager at the care home

at the material time. Their evidence was not entirely in agreement although they both agreed that JD had signed the Consent Forms.

141. Witness C stated that Patient 1 had limited capacity as she had mental health issues. He said that Patients 3-4 lacked capacity to participate in a MUR and a 'Best Interest Meeting' would have been needed for a MUR to take place. He said that MURs at the care home were conducted by the resident's GP and that mainly he or otherwise a competent member of staff would be involved in the review.

142. Witness B stated that the role of a Support Worker was to allow the resident to do as much as they could themselves whilst supporting them. He said that residents did not have an understanding of their medications or what they were for so a Support Worker would help with that. Whilst he did not recall signing any MURs, he said this was potentially something that a Support Worker could or would do. He confirmed that Support Workers did sign documents on behalf of residents who did not have capacity. He stated that normally when a MUR took place with a patient without capacity, a staff member would discuss this with the patient's GP or pharmacist on behalf of the patient while the patient was with them. The staff member would give feedback on how the patient had been, how their medication had affected them and whether it needed changing.

143. The Registrant confirmed that he kept a folder at the Pharmacy with all the completed Consent Forms and that MURs, which lasted around 10-15 minutes, took place in a private room with the patient. He stated that when conducting MURs he could access the PMR system from the consultation room but it was not always available when the Pharmacy was busy, so he would keep notes on a piece of paper and log them onto the PMR later. He explained how he conducted a MUR and what issues were discussed. In relation to Patients 1-4, he remembered seeing them on occasion in the Pharmacy but could not remember their MURs. He stated that a carer could consent to a MUR but a patient should always be there with the carer. He did not recall having any issues concerning the mental capacity of these patients, all of them having a carer with them at the time. He said that it was a matter of

professional judgement but he did not remember doing these MURs on these patients.

144. The Registrant confirmed he had not conducted any MURS since 2019 when he left the pharmacy so could not now remember how they worked on the system. He stated that the system showed they had taken place, therefore they must have been done. The Registrant had provided photographs showing another patient from the care home in the pharmacy on two separate occasions, with two different Support Workers. This had been confirmed by Witness B.

145. The Committee carefully considered all the documents provided. The MUR forms all contained the exact date and time, including seconds, of when they had been entered. This had been automatically entered by the computer system. Critically, the MURs for Patients 3 and 4 were only 15 minutes apart on the same day which indicated it was more likely than not that their MURs had taken place on the same day one after the other. On all of the MURs, various boxes had been ticked to indicate what discussions had taken place and the advice given.

146. As JD had not been called to give evidence, there was no evidence about what had actually happened on each of the relevant dates. There was clear evidence from the photographs that Support Workers did take residents from the care home into the Pharmacy. The Committee concluded that it was more likely than not that on each of the respective dates, JD had taken the patient(s) to the Pharmacy, she had signed the respective Consent Forms on their behalf and the MUR had been conducted immediately on the same day with JD and the patient in the consultation room. The Allegation was that reviews had not been undertaken and the Committee did not need to consider whether they had been done adequately. Accordingly, Committee found Items 1-4 of Schedule C not proved**.**

<u>Items 6 and 7 – Patient 6</u>

147. These items concerned alleged claims for MURs dated 19 December 2018 and 29 January 2019 concerning Patient 6, a Pharmacy Technician, who gave evidence. She accepted her signature was on the Consent Forms but said that she had never had a MUR. She vividly recalled a man coming to her door, claiming to be from the Pharmacy asking her to sign two forms, hours apart on the same day, but she could not confirm what the forms were for. She was adamant that she had never been prescribed Atorvastatin but the Committee was subsequently provided with a copy of her PMR which showed she had been prescribed this from July 2018 to December 2018.

148. The Consent Forms provided relating to Patient 6 were dated 29 December 2018 and 29 January 2019. The Registrant had provided a copy of the MUR form for Patient 6 which was dated 29 December 2018. It confirmed the date of the next review as 29/12/2019. The Allegation pleaded the date of the first MUR at Item 6 as 19 December 2018. There was no evidence of a record for a MUR dated 19 December 2018. The MUR Summary Report from the Pharmacy did not contain any record or claim for a MUR on 19 December 2018. The Committee therefore found Item 6 not proved on the documents.

149. In relation to Item 7, which related to a MUR dated 29 January 2019, the Registrant had stated that only one MUR had been undertaken and claimed for Patient 6 and this was dated 29 December 2018. The MUR Summary Report did not contain any record or claim for a MUR dated 29 January 2019. The Committee therefore found Item 7 not proved on the documents.

150. The Committee found Items 6 and 7 of Schedule C not proved.

<u>Items 8 and 9 – Patient 5</u>

151. These Items concerned alleged MUR claims made on 31 May 2019 and 16 July 2019 in relation to Patient 5. Two Consent Forms had been provided dated 31 May 2019 and 16 July 2019. The MUR Summary Report included a record of only one MUR

dated 16 July 2019. There was no evidence of a record or claim for a MUR dated 31 May 2019 and therefore the Committee found Item 8 not proved on the documents.

152. The Registrant had provided a copy of the MUR for Item 9, dated 16 July 2019. Various boxes had been ticked on the form indicating the advice given and discussions that had taken place.

153. The Council relied on a witness statement from Patient 5, but had not called her to give evidence. Patient 5 confirmed her signature was on the Consent Form but could not remember signing the Form or the circumstances around doing so. She stated that she remembered participating in a private consultation to discuss her medications but stated this was at the old premises. Her evidence was not tested on cross-examination and therefore the Committee attached little weight to it.

154. The Registrant remembered Patient 5 as he said she had an interesting story in that her husband was a GP who had owned a practice opposite the old premises and she was the first patient to come into the Pharmacy. He said Patient 5 was sad that her husband had passed away. He said she had been a frequent visitor to the Pharmacy and she had had multiple medical reviews at both the old and new premises. In his witness statement he stated that he remembered doing a MUR with Patient 5 at the new location, but said he may not have used the phrase MUR when discussing this with her.

155. As Patient 5's evidence had not been tested and there was evidence of a MUR being undertaken on 16 July 2019, the Committee concluded based on the Registrant's evidence that it was more likely than not that a MUR had taken place on this date. The Committee found Item 9 not proved.

<u>Items 10 – 14 – Patients 377, 378, 379, 337 and 380</u>

156. These Items were all in relation to MUR claims for MURs dated on a bank holiday. No copies of the MUR forms had been provided. The Council relied on the MUR Summary Report which showed the MURs for Patients 377, 378, 379 and 377 were

dated 19 April 2019 and the MUR for Patient 380 was dated 6 May 2019 which were bank holidays.

157. An undated Consent Form had been provided for Patient 337. No Consent Forms had been provided for Patients 377, 378, 379 and 380. Both parties accepted that their Consent Forms had been provided by the Pharmacy to NHS England, who had then sent them to the NHS Counter Fraud Authority. The Consent Forms had been requested by the Council but had been lost somewhere by the NHS.

158. The Registrant confirmed in his evidence that the Pharmacy was not open on bank holidays. He said that sometimes when he was conducting MURs, he would make handwritten notes when he was particularly busy, and then log the MURs onto the system the following day or whenever he could. He said that he regularly went into the Pharmacy over the weekends and on bank holidays to catch up with work while the Pharmacy was closed.

159. The Committee accepted the Registrant's explanation. It was not unusual for pharmacists, or indeed other professionals, to go into work in order to catch up with paperwork at the weekend or on bank holidays. Furthermore, if the Registrant had intended to fraudulently create MURS, then it was more likely than not that this would not have been done on a bank holiday. It was also unlikely that he would only submit a handful of fraudulent claims when compared to the overall number of MURs submitted for payment by the Pharmacy. The Committee was satisfied that it was more likely than not that these MURs had been undertaken.

160. The Committee found Items 10 to 14 of Schedule C not proved.

<u>Items 15-18 – Patients 381, 382, 383 and 384</u>

161. The Council relied on the fact that no Consent Forms had been provided for these patients. The MUR Summary Report confirmed that MUR were recorded and claims had been made on 18 October 2018 (Patient 381), 21 January 2019 (Patient 382), 15 January 2019 (Patient 383) and 4 January 2019 (Patient 384).

162. The Registrant stated in evidence that by the time the Consent Forms had been requested by NHS England, he had left the Pharmacy so he did not know whether they had been provided or whether they had been missing from the relevant folder. He said that he had tried his best to keep things in order but he was not able to say whether these Consent Forms had been provided or not. He stated that the MURs had definitely been done as they were showing on the system. He confirmed that all the Consent Forms had been kept in an A4 folder and were not removed. He also confirmed that when the Pharmacy moved from the old premises to the new premises, the Consent Form folder was also taken to the new premises.

163. The Committee noted that there was no evidence from any of the patients relating to these MURs. The MURs were all dated at a time when they would have been conducted at the old premises, as the Pharmacy did not move to the new premises until February 2019. The Committee concluded that it was more likely than not that these Consent Forms had been misplaced, perhaps during the move. There were potentially a number of reasons why they perhaps could not be found – they could have been placed in the wrong folder, they could have been lost or the MURs could have taken place without a Consent Form being completed on these occasions, if the patient had been taken straight into the consultation room for the review when attending the Pharmacy. Whilst no copies of the MURs had been provided, the MUR Summary Report, which was taken from the system showed a claim for these MURs. The Committee was not satisfied that the lack of Consent Forms was sufficient evidence that these MURs had not taken place or that fraudulent fees had been claimed. Accordingly, the Committee found Items 15 to 18 on Schedule C not proved.

<u>Item 19 – in relation to the Registrant</u>

164. This matter related to a claim for a MUR on the Registrant dated 2 September 2019. A copy of the MUR Form had not been provided. The MUR Summary Report recorded that this MUR had been carried out by the Registrant, but by September

2019, he had left the Pharmacy. The RP Log confirmed Pharmacist 1 was the RP on 2 September 2019.

165. The Registrant, in evidence, confirmed that he had not returned to the Pharmacy after he left. He did not do any locum work there. The Smartcard log provided showed that the Registrant had not logged onto the computer system at the Pharmacy since 14 August 2019.

166. The Committee concluded there was no evidence that the Registrant had fraudulently recorded or claimed for a MUR on himself dated 2 September 2019 when such a MUR had not taken place. The Committee found Item 19 on Schedule C not proved.

167. **The Committee found Allegation 7 not proved.**

Allegation 8

8. On one or more occasions you submitted or allowed to be submitted, an FP34 form to claim fees for fraudulent MURs in Schedule C and / or Schedule D.

168. The Committee had already found the Items in Schedule C not proved so did not consider these any further. In relation to Schedule D, it was alleged that in March 2019 and in July 2019 claims had been submitted for 7 patients in each of those months where there was no record of MURs taking place.

169. The Council relied on Witness A's evidence for this Allegation. He had stated that NHS pharmacies were required to submit a FP34 Form on a monthly basis. This form set out data which was directly relevant to the amount of fees a pharmacy could claim from NHS England for NHS Services. Witness A confirmed that the declaration on the FP34 Form could be delegated to a member of staff who was appropriately trained and competent to complete the form.

170. The Registrant in his second witness statement dated 13 May 2024 had provided the table which tallied the number of MURs recorded on the Pharmacy's PMR against the number claimed in each month's FP34 Form. This showed the following:

Month	Number recorded in PMR	Number claimed in FP34
September 2018	33	29
October 2018	28	28
November 2018	26	28
December 2018	33	30
January 2019	29	30
February 2019	32	28
March 2019	21	28
April 2019	30	32
May 2019	31	27
June 2019	41	39
July 2019	25	32
	329	**331**

171. The Registrant confirmed that there were some months when the number of claims submitted were less than the number recorded on the PMR. He said that some claims could have been done in different months and some could have been counting errors. He confirmed that the counting had been done by himself, Person C and Pharmacist 1. Person C had confirmed in her evidence that she had completed some parts of the FP34 Form on the Registrant's instructions. The Registrant accepted he had responsibility for ensuring the accuracy of claims submitted but denied any dishonesty.

172. It was clear to the Committee that there were some months when more claims had been made than MURs recorded but then there were other months when less claims were made than MURs recorded. For example, in September 2018, 33 MURs were recorded on the PMR but only 29 claims had been submitted. In February 2019, 32 MURs were recorded but claims were only made for 28. In May 2019 31 MURs were recorded but claims had only been made for 27.

173. There was no information about the identity of the 14 patients referred to, so it was not known who the claims related to. It was clear to the Committee that the table provided showed this was an issue of balancing claims. There may have been poor procedures in place to ensure the exact number of MURs conducted each month

were claimed but this did not mean that the claims had been submitted fraudulently as alleged. The Committee was satisfied that it was more likely than not that the claims for MURs conducted had been spread over a couple or so months which had led to the inaccuracy in the number of claims submitted. It was more likely than not that there had been accounting errors in the months of March 2019 and July 2019. There was insufficient evidence that these claims had been made fraudulently.

174. **The Committee found Allegation 8 not proved**.

Allegation 9

9 Your actions at Allegations 7 and/or 8 above were dishonest in that you knew that the MURs had not been undertaken and / or the pharmacy was not entitled to payment.

175. As Allegations 7 and 8 were not proved, it followed that Allegation 9 was not proved.

176. **The Committee found Allegation 9 not proved**.

Allegation 10

10. You created false records for the pharmacy in that you, on one or more occasions:

10.1 instructed staff not to record near misses and/or dispensing errors,
10.2 created or caused to be created false reports of near-misses,
10.3 created or caused to be created false reports of medication errors,
10.4 when acting in the role of RP, failed to record your absences from the pharmacy in the RP log.

<u>Allegations 10.1, 10.2 and 10.3</u>

177. The Council relied on Person C's evidence alone for this Allegation. She had stated that the Registrant had told her to create records of false dispensing and other errors so as not to raise questions in the event of an inspection by the GPhC. She was unable to recall specific examples, dates or details of which entries were false. Her

evidence was therefore not reliable. No documentary evidence was provided to support this Allegation.

178. The Registrant denied ever asking staff to invent or create false records. He said that he encouraged staff to record any errors they made as it would demonstrate good processes in the dispensary.

179. As there were no documents or contemporaneous records to support this Allegation, the Committee found the Allegations 10.1, 10.2 and 10.3 not proved.

Allegation 10.4

180. The Council relied on the RP Log which showed that the Registrant's absences from the Pharmacy on the days he was the RP had not been recorded. The Committee had already determined that there had been periods during some days when he had been away from the Pharmacy whilst he was registered as the RP and he had admitted this in his evidence.

181. The Registrant's evidence on his absences is set out at Allegation 1 above. He stated that his absences were short and said that he had been taught at university that a pharmacist could be absent for up to two hours from the pharmacy. He stated that at the material time his knowledge had been very basic and he had not realised that every absence from the Pharmacy, no matter how short, should have been logged. He had not realised at the time that even lunch breaks needed to be recorded and he now accepted that every absence, even if it was for only a few minutes while he had a smoke in the alleyway, should have been recorded. The Registrant stated that when he had worked as a locum, he had never seen anyone else sign in and out of the RP Log for absences and nor had he been asked to do so when he took his lunchbreaks.

182. The Committee was satisfied that the Registrant had not recorded his absences in the RP log whilst acting in the role of RP. This was based on both the RP Log and his admission. The Committee found Allegation 10.4 proved.

183. **The Committee found Allegations 10.1, 10.2 and 10.3 not proved. The Committee found Allegation 10.4 proved**.

Allegation 11

11. Your actions as set out in Allegations 10.1 and/or 10.2 and/or 10.3 and/or 10.4 were dishonest.

184. As the Committee had found Allegations 10.1, 10.2 and 10.3 not proved, it followed Allegation 11 was not proved in relation to them.

185. The Committee considered whether the Registrant had acted dishonestly in relation to Allegation 10.4. It applied the test in Ivey v Genting Casinos. The Committee took into account that the Registrant had been at an early stage of his career and had previously only worked as a locum pharmacist. He had confirmed that he was aware from his training that pharmacists could be absent for up to two hours. The Committee had heard evidence from VR confirming the Registrant's absences were generally around 20-30 minutes. The Committee had already found he was sometimes absent for up to an hour. There was often a locum working on the days that he was not there.

186. The Committee accepted the Registrant's evidence that he had not known that he needed to sign absences of less than 2 hours in the RP Log. He had therefore not deliberately failed to record when he was away from the Pharmacy. The Committee was satisfied that, particularly given the Registrant was at an early stage of his career, this conduct would not be regarded as dishonest by the standards of ordinary decent people. The Committee concluded the Registrant had not acted dishonestly.

187. **The Committee found Allegation 11 not proved**.

Allegation 12

12. You failed to ensure the safe and effective delivery of services in the pharmacy in that you:

12.1 employed inexperienced staff and then instructed them to act beyond their competency

12.2 lied to, or instructed staff to lie to, people who came to the pharmacy,

12.3 continued to use a Smartcard assigned to Person C after she had ceased to be employed at the pharmacy.

Allegation 12.1

188. The Council relied on the evidence of Person C for this Allegation. She had described how she had received an induction when starting work at the Pharmacy, she explained the various processes involved in labelling, dispensing medication and checking expiry dates. She agreed she had done well on her Buttercups training course and had passed most of the modules with good marks. She agreed she asked the Registrant for help when he was there and he had helped her with her training.

189. The Registrant's evidence was that Person C was carrying out basic jobs in the Pharmacy and had only started full dispensing after she had started the Buttercups course in December 2018. Prior to that, he said that any dispensing was done under his direct supervision. The Registrant stated that Person C knew exactly what she needed to do, she had been trained by the Registrant, VR, and Pharmacist 1 and she was aware of steps such as checking expiry dates and ensuring medication leaflets were given to patients when appropriate. He accepted it was possible that Person C had given medication to patients when he was not there and she should not have done this. He agreed that this would have been acting outside her competency.

190. The Committee noted that there was no evidence of any complaints from patients. It was mindful that competency was often acquired through experience and training on the job. Person C had clearly been working well in the Pharmacy as the results from her Buttercups course demonstrated her competence in a number of areas. However, the Committee had found that the Registrant had not been at the Pharmacy on a

number of occasions and had instructed, by using electronic communication, Persons A and C to supply medications to patients. He had not been present in the Pharmacy on those occasions to adequately supervise Persons A and C, or to intervene and give advice if required. He had not adequately checked what medications were being given out and he had accepted Person C was not competent to be giving medicines to patients when he was not there. The Committee was satisfied that as a Trainee Dispenser, Person C had been inexperienced and had been instructed to act beyond her competence when told to supply patients with medications when there was no pharmacist on the premises. The Committee concluded that this did not amount to the safe and effective delivery of services in the Pharmacy because there had been inadequate supervision of Person C and inadequate checking of prescriptions and medications before they were supplied to patients in his absence, as well as no pharmacist available to deal with patient queries.

191. **The Committee found Allegation 12.1 <u>proved</u>**.

<u>Allegation 12.2</u>

192. The Council's case was that the Registrant had told staff to lie to patients by telling staff to tell patients he was not in the Pharmacy when he was. It was accepted by the Council that this was usually to avoid patients who had addiction issues. The Council made specific reference to incidents on 10 May 2019 and 13 May 2019.

193. The Registrant, in his evidence, had admitted he had hidden from Patient 8 and that he had told staff on 13 May 2019 to tell Patient 8 to come back the following day. He could not recall why he had said this. He stated in his witness statement that Patient 8 was a diazepam and morphine addict who would regularly try to get emergency supplies from local pharmacies. Person C had confirmed in her evidence that Patient 8 wanted to see the Registrant all the time and would want his medications early.

194. The Registrant said that he very rarely asked staff to lie to patients and he would always see patients, but on occasion he would ask them to return later or the

following day. He said that he would never completely avoid them, as frequently they only wanted to speak to him. He stated that on a weekday he could speak to Patient 8's doctor but that was not possible on a Saturday. The Registrant accepted telling staff to tell patients that he was unavailable when he was at the Pharmacy, was not being truthful with patients and that he should have seen them but he also pointed out that there could be occasions when he was at lunch or busy with other work in the Pharmacy when patients wanted to see him. He accepted that in that moment it had not been the right thing to do but stated it was only with patients who kept coming back and would stay persistently, even if the Registrant had seen them the day before. He agreed that such behaviour was dishonest "*in that moment*".

195. The Committee noted, based on the Registrant's admission and the content of the WhatsApp messages, that there had been two occasions when he had instructed staff to tell patients he was not in the Pharmacy. This had happened with Patient 8 on 13 May 2019 and with another patient on 27 March 2019.

196. In relation to 10 May 2019, which the Council also relied upon, again concerning Patient 8, it appeared from the WhatsApp messages that a locum pharmacist was working that day. Patient 8 had attended the Pharmacy at 13:35 and Person C sent a WhatsApp message to the Registrant stating Patient 8: *"wants to know if I can do his prescription".* The Registrant replied: "*It's Ishy's decision"* referring to the locum. Person C informed the Registrant that the locum was not there, to which the Registrant stated: *"Oh okay say come Tom"*. On this occasion the Committee was satisfied that the Registrant was more likely than not away from the premises as he words "*Oh Okay*" implied he had not known the locum was not there. The Registrant had said it was the locum's decision which indicated he believed the locum was there to deal with Patient 8. It was possible the locum could have been at lunch around this time. The Committee was satisfied that on this occasion the Registrant had not instructed staff to lie about his whereabouts, as he was more likely than not, not on the premises.

197. The WhatsApp messages showed that on 27 March 2019, when a patient had asked to see him, the Registrant had replied "*I can't come out now…. Say he's out….. Come back later"* and he had then asked Person C: "*What did you say? ….. I was shitting or out…"* Person C's reply was "*I said you was here but unavailable."* The Committee concluded from this that the Registrant was more likely than not, on the premises at this time. Whilst he had told Person C initially to say he was "*out*", he then questioned whether Person C had informed the patient that he was in the lavatory. In any event, the patient had been told he was at the Pharmacy but unavailable. The staff had not therefore lied to the patient that day.

198. There was a second incident concerning Patient 8 on 13 May 2019. On this occasion, the Registrant was told by Person C on WhatsApp that Patient 8 was in the Pharmacy. The Registrant sent a message back stating: "*Say he's not here come back Tom"* which indicated he was willing to see Patient 8 the following day. It was clear the Registrant was entering the premises as he also stated in the messages to Person C: *"Plz open back door I'll come from back… Check from kitchen… I will not see him…. Plz ignore him …. Open bar door locked …."* This showed that the Registrant was just outside the back of the Pharmacy coming back in to the premises at the material time. Person C had replied: "*He's gone*" 9 minutes later. The Committee was satisfied that the Registrant had told staff to lie to Patient 8 by asking Person C to tell Patient 8 the Registrant was not in the Pharmacy and to return the following day when he was at the Pharmacy. It was clear that the Registrant had deferred when he would see Patient 8, although he did not give a specific reason for this. He had delayed seeing this patient to the following day.

199. This Allegation had been pleaded on the basis that the Registrant had failed to ensure the safe and effective delivery of services in the Pharmacy. The Committee therefore went on to consider if, on 13 May 2019, the Registrant had not delivered safe and effective care to Patient 8. It was clear from the WhatsApp messages that Patient 8 was a frequent visitor to the Pharmacy and regularly demanded to see the Registrant to request emergency supplies of medication. He was also a patient who

would refuse to leave the Pharmacy and would sit and wait for the Registrant as long as required.

200. The Committee was satisfied that if a pharmacist was on the premises, then he/she should not be telling staff to lie to patients and say that the pharmacist is not at the premises when he/she is. This places pressure on junior staff to deal with potentially difficult situations where patients and/or staff may need support from a pharmacist. However, on this occasion on 13 May 2019, there was no evidence before the Committee to show that safe and effective services had not been delivered to Patient 8, who had been asked to return the following day and had left when offered this option. There was no evidence that he required urgent advice or emergency medication. The Committee was not satisfied that the Council had proved that, in telling staff to inform Patient 8 he was not at the Pharmacy and deferring seeing the patient to the following day, there had been a failure by the Registrant to ensure the safe and effective delivery of services in the Pharmacy.

201. **The Committee therefore found Allegation 12.2 not proved**.

Allegation 12.3

202. The Council relied on the evidence of Person C for this Allegation. She said that her and the Registrant's Smartcards were always left in the computer at the Pharmacy. She said that when she left the Pharmacy in June 2019, she left her Smartcard at the premises. After she had spoken to Witness A on 25th July 2019, he had told her to go back to the Pharmacy and collect her Smartcard. Person C said that she returned to the Pharmacy shortly after this and the Registrant had returned her Smartcard to her, but her name and face had been covered up on the card with a white label.

203. The Registrant in his evidence confirmed that he had his own Smartcard and had no need to use Person C's Smartcard. He explained that his Smartcard would usually be in the keyboard of the server computer. He would need to log in to download prescriptions. Once he had logged in on his Smartcard, this would allow both the server computer and the client computer to be used with the same login at the same

time. He confirmed that at the end of the day, or if the computer went to sleep during the day, the Smartcard would be logged out and would have to be logged in again. Once his Smartcard was logged in again, both computers would work together as the server computer refreshed both.

204. The Registrant stated that when Person C had left the Pharmacy, it was very chaotic and he did not even know that she had left her Smartcard behind. He said that usually a Smartcard would be kept with the person it belonged to and in the past his own Smartcard had been put in the confidential waste at previous pharmacies when he had left it behind. The Registrant stated that when Person C came back to the Pharmacy and asked for her Smartcard, he had no idea where it was. He said it was still in the keyboard of the computer where she had left it. He confirmed that locums have their own Smartcard and he had employed other staff and locums after Person C left. He did not recall seeing Person C's name and face being covered up on her Smartcard but said that when she had come back into the Pharmacy, he had not wanted to deal with her and just gave the Smartcard back to her. The Registrant stated that he used the server computer and the other client computer was used by other staff and locums who needed to access prescriptions.

205. The Committee noted that a record had been provided showing that Person C's Smartcard had last been accessed on 25 July 2019 which coincided with the date that she has spoken to Witness A and then gone back to the Pharmacy to collect her Smartcard. There was no evidence of Person C's Smartcard or of her face and name on the card being covered up. Nor was there any evidence that the Registrant had used the card. The Committee accepted he had his own Smartcard so there was no need for him to use Person C's Smartcard. Indeed, his Smartcard would operate both computers and Person C's Smartcard would have logged out by the end of the day when she left the Pharmacy. The Committee concluded that there was no evidence that the Registrant had used Person C's Smartcard after she left employment with the Pharmacy and found this allegation not proved.

206. **The Committee found Allegation 12.3 not proved.**

Allegation 13

13. Your actions as set out in Allegation 12.2 were dishonest.

207. As Allegation 12.2 was found not proved, it followed that Allegation 13 was also not proved.

208. **The Committee found Allegation 13 not proved.**

Submissions on Misconduct and Impairment

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

210. 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 states:

> *"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."*

211. The Committee took into account the documents provided, the submissions made by both parties and the Registrant's evidence.

212. Mr Geering referred the Committee to the case of Meadow v General Medical Council [2007] 1 All ER 1, in which Auld LJ stated:

> *"200……. As to seriousness, Collins J. in Nandi v General Medical Council [2004] EWHC 2317 (Admin), rightly emphasised at [31] the need to give it*

proper weight, observing that in other contexts it has been referred to as "conduct which would be regarded as deplorable by fellow practitioners."

213. Mr Geering also referred the Committee to the case of Shaw v General Osteopathic Council [2015] EWHC 2721 (Admin) in which Kerr J stated:

> "47……. 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."

214. Mr Geering submitted as follows in relation to misconduct on each of the proved Allegations:

- Allegations 1 and 2.1 – There had been a breach of Standards 1, 6 and 9 of the GPhC Standards for Pharmacy Professionals (May 2017) ("the Standards") as well as a breach of the Human Medicines Regulations 2012. Mr Geering submitted misconduct was proved as the Registrant had allowed the supply of medications when he was not present or had not adequately supervised Persons A and C, which could have led to potentially serious harm to patients.
- Allegation 2.2 – There had been a breach of Standard 7 and a breach of the General Data Protection Regulations ('GDPR') which amounted to misconduct. Mr Geering submitted that sensitive patient details had been stored on a personal device belonging to a staff member and had continued to be stored there.
- Allegation 3.1 – There had been a breach of Standards 1 and 6 which amounted to misconduct. Mr Geering submitted that by failing to ensure there was supervised consumption of a CD, the Registrant had bypassed the safeguards that were in place to protect patients.
- Allegation 4 – There had been a breach of Standards 6 and 9 which amounted to misconduct. Mr Geering submitted there were sound reasons for restricting access to CDs and in this case access to CDs had not been secured.
- Allegation 5 – Mr Geering had no observations to make on this Allegation.

- Allegation 10.4 – There had been a breach of Standard 6 and a breach of the relevant Royal Pharmaceutical Society Guidance on Responsible Pharmacist and regulations in relation to the lack of recording absences on the RP Log. Mr Geering submitted the regulations were in place for effective accountability and this was a serious matter. He submitted that it was not sufficient for the Registrant to rely on his observations of others not recording their absences as they were also breaching the regulations. Mr Geering submitted misconduct was proved.
- Allegation 12.1 – Mr Geering submitted this overlapped with Allegations 1 and 2.1. He submitted misconduct was proved as Persons A and C had supplied medications to patients beyond their skills which had put patients at risk.

215. In relation to impairment, Mr Geering submitted the Committee should consider Rule 5(2)(a), (b) and (c) of the Rules. He confirmed the Council did not rely on Rule 5(2)(d) of the Rules. He submitted the Registrant had demonstrated poor practice, there had been a number of repeated failures over a period of time and although the Registrant had worked well since then, had provided reflections and good testimonials, the work he had done since these events was not in comparable circumstances. He submitted the Registrant had not worked as a RP since leaving the Pharmacy and there was a potential risk of repetition of the Registrant's conduct.

216. Mr Geering also submitted that even if the Committee were to find there was no risk of repetition, the public interest required a finding of impairment due to the Registrant's widespread failures, numerous breaches and the risk of harm patients had been exposed to. He submitted the maintenance of public confidence and the need to uphold professional standards required a finding of impairment.

217. Mr McCartney, on the Registrant's behalf, did not seek to persuade the Committee that misconduct was not proved in relation to Allegations 1, 2 and 12.1. He accepted that Allegations 3 and 4 could amount to misconduct but submitted the conduct in Allegation 5 had been an error and therefore not misconduct.

218. Mr McCartney submitted Allegation 10.4 did not amount to misconduct. Whilst he accepted there had been a breach of the regulations and absences should have been recorded, he submitted that not every breach amounted to misconduct. The Registrant had observed others not recording absences and although that was not part of the Committee's considerations, it appeared to be common not to record short absences. Mr McCartney submitted this did not amount to a serious omission and would not be regarded as deplorable in the eyes of fellow practitioners.

219. In relation to impairment, Mr McCartney reminded the Committee the events were from 5 years ago and he particularly noted the Committee's findings at paragraph 71 of its Decision on Facts about the Registrant being out of his depth when agreeing to run the Pharmacy, taking on too much at an early stage of his career with no real understanding of the responsibilities of the roles of a SI and RP. This had been accepted by the Registrant before the Committee's findings and was dealt with in his witness statement. Mr McCartney submitted the conduct complained of was capable of remediation and had already been remediated. He stated the Registrant had been working as a locum RP in a local family owned pharmacy and there had been no issues. Mr McCartney accepted this was not in the role of a SI but submitted there was no risk of repetition as the Registrant's obligations were as a pharmacist, whether as a RP or a SI.

220. Mr McCartney reminded the Committee that the Registrant had removed himself from the Pharmacy as soon as the issues had been raised with him and had had no involvement since then which demonstrated significant insight. He had also undertaken CPD, reflections and dealt with his shortcomings at length in his witness statement. Mr McCartney submitted the Registrant had shown insight, he had accepted his conduct prior to the Committee's findings and had addressed the conduct found proved. He submitted the Registrant now understood he had taken on too much too quickly and had set out in detail how he would do things differently now. Mr McCartney submitted there was no risk of repetition and no risk to patient safety.

221. Mr McCartney accepted that there was a need for the Committee to uphold standards of behaviour and did not seek to persuade the Committee that there should be no finding of impairment in the public interest, but this should not be on the basis of a risk of repetition of the Registrant's conduct.

Decision on Misconduct

222. The Committee considered each of the proved Allegations in turn and whether the Registrant had breached any of the Council's Standards for Pharmacy Professionals (May 2017).

Allegations 1 and 2.1

223. The Committee determined that there had been a breach of the following Standards in relation to Allegations 1 and 2.1:

a. Standard 1 - Pharmacy professionals must provide person centred care.
In allowing unqualified staff to supply patients with prescription only and pharmacy medications when there was no pharmacist on the premises, and inadequately supervising using Whatsapp messages when he was in the lavatory at the premises, the Registrant had not made the care of patients his first priority. He had not thought about the impact his decisions would have on others and had thereby placed patients at the risk of potential harm because medications had not been properly checked before supplying to patients. These included heart medications, anti-depressants, painkillers containing codeine and antibiotics. Nor had he been available to deal with any queries patients may have had or been there to give advice or intervene if necessary.

b. Standard 5 - Pharmacy professionals must use their professional judgement.

The Registrant had failed to use his professional judgement and provide appropriate care in that he could not check the PMR, or the medications inside the dispensed packaging, before authorising their supply by WhatsApp messages to patients when he was not on the premises. He had also failed to use his professional judgement in authorising the supply of medications using electronic messaging when he was absent from the premises as this was not an appropriate method of supervising the supply of prescription only and pharmacy medications.

c. Standard 6 – Pharmacy professionals must behave in a professional manner.

Authorising the supply of medications to patients using WhatsApp messages while away from the premises was not acting in a professional manner. This was not appropriate behaviour for a pharmacist and did not maintain public trust and confidence in the pharmacy profession. Members of the public expect pharmacists to check medications properly before they are supplied to patients and to be available to provide advice and guidance about those medications if required.

d. Standard 9 – Pharmacy professionals must demonstrate leadership.

The Registrant had not demonstrated leadership as he had not led by example. He had not assessed the risks of failing to properly check medications and authorise their supply by using WhatsApp messages. He had not assessed the risks of allowing unqualified staff to supply prescription only and pharmacy medications to patients while he was absent from the premises and therefore unable to deal with any possible queries from patients. He had not kept these risks as low as possible. He had failed to lead by example, particularly in relation to Person C, who was training to become a pharmacy professional.

224. The Committee was also satisfied that there had been a breach of the Human Medicines Regulations 2012 as the supply of prescription only medications had been carried out by unqualified staff who were not adequately supervised.

225. 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).

226. The Registrant's conduct in relation to Allegations 1 and 2.1 had taken place over a period of just under 3 months. It involved numerous patients and whilst there was no evidence of patient harm, there had been a potential for patient harm. The Committee had no doubt that the Registrant's conduct was very serious. It fell far short of what was proper in the circumstances and fellow practitioners would consider it to be deplorable. The Committee found the conduct in Allegations 1 and 2.1 amounted to misconduct.

Allegation 2.2

227. The Committee found there had been a breach of Standard 7 – Pharmacy professionals must respect and maintain a person's confidentiality and privacy. In this case the Registrant had allowed acutely sensitive patient information, which included patient names, addresses, dates of birth, ages and copies of their prescriptions containing their NHS numbers, medication details and GP information, to be stored on personal devices belonging to staff. Photographs of medications and prescriptions had been sent to the Registrant from 28 January 2019 until around 14 June 2019, a period of about 4½ months. This was a clear breach of GDPR. The Committee had no doubt that patients would have been shocked and horrified to learn that photographs of their private, very personal, medical related data was being sent by WhatsApp photographs between pharmacy staff and stored on the mobile phone of at least one member of staff. Indeed, Person C had provided these photographs from her mobile phone many months after the messages had been sent indicating she had kept the photographs on her personal device for some time after leaving the Pharmacy.

228. The Committee had no doubt that this was very serious conduct which fell far short of what was proper in the circumstances. Fellow practitioners would consider it to be deplorable. The Committee was satisfied that the conduct in Allegation 2.2 amounted to misconduct.

Allegation 3.1

229. The Committee found there had been a breach of Standards 1, 5 and 6. Although the Registrant's reasons for allowing a patient to take home Buprenorphine medication on one occasion had been to help and accommodate the patient's religious beliefs, the Registrant had not given proper consideration to the impact of his decision on that patient or on the wider public. The Registrant may have thought at the time that he was providing person centred care, but he had failed to consider the associated risks, such as the medication being sold, hoarded or not taken properly. This had the potential to cause more harm to the patient and/or to members of the public. Safeguards were in place by ensuring supervised consumption of such CD medication to address these risks. The Registrant had shown a lack of professional judgement by failing to consider these risks and he had not acted in a professional manner by failing to comply with the standards required.

230. The Committee was satisfied that this was serious conduct which fell far short of what was expected in the circumstances. The Committee was satisfied that fellow practitioners would consider this conduct deplorable. The Committee found the conduct in Allegation 3 amounted to misconduct.

Allegation 4

231. The Committee found there had been a breach of Standards 5 and 9 in relation to Allegation 4. The Committee had found there had been at least one occasion when Person C had accessed the CD Cabinet when the Registrant was not on the premises and there was no other pharmacist supervising. The Registrant had failed to use his professional judgement by allowing the keys to the CD Cabinet to be stored in the safe, which Person C had access to, thereby allowing her to have access to the CD Cabinet. He had failed to demonstrate leadership as he had not put good procedures in place to ensure the safe custody of CDs.

232. The Committee was satisfied that this was serious conduct that fell far short of what was proper in the circumstances. CDs are high risk drugs and there are good reasons for ensuring they are kept safe and secure. The Committee was satisfied that fellow practitioners would consider this conduct to be deplorable and that the conduct in Allegation 4 amounted to misconduct.

Allegation 5

233. This related to a claim for payment for one item which had not been supplied. The Committee had already found that this claim had been made inadvertently in error, without anybody checking or correcting it. The Committee had been satisfied that the Registrant had not known the claim had been made. This had been an isolated error in the context of moving premises. In these circumstances, the Committee was satisfied this conduct was not so serious as to amount to misconduct.

Allegation 10.4

234. The Committee was satisfied that the Registrant had breached Regulation 5(1)(e)(i)-(iii) of The Medicines (Pharmacies) (Responsible Pharmacist) Regulations 2008 in that he had failed, when he was the RP, to record the date and time of his absences as well as the time that he returned to the Pharmacy. These regulations are in place to ensure there is accountability in relation to who is responsible and in charge of a pharmacy at any given time. The Committee was also satisfied that the Registrant had breached Standard 6 in that failing to comply with regulations was not behaving in a professional manner.

235. The Committee had already found that the Registrant had not been absent for more than two hours and had accepted his explanations that he had not known absences of less than two hours should be recorded, nor had he seen other pharmacists recording their absences. This was no excuse as the Registrant ought to have known the requirements of the regulations. However, the Committee took into account that he had been recently qualified at the material time and had followed the example of others. In the context of this specific case, the Committee was mindful that when

the Registrant was the RP, he was the only pharmacist on duty at the Pharmacy, he (and other locums) had signed in at the beginning of the day and signed out at the end of the day, so it was clear who was accountable as the RP on any particular day.

236. The Committee also noted that on 10 May 2019, the Registrant had signed in as the RP from 08:53, then signed out at 09:00 as another locum signed in at 9:00. That locum worked until 12:11, when the Registrant signed back in as the RP and continued working until 18:00. There were other instances where this happened and this demonstrated the Registrant had signed the RP Log when he was absent for more than 2 hours or when he was not the RP on duty.

237. The Committee concluded that although there had been a breach of the regulations and a breach of Standard 6, failing to record absences in this case, which had been an omission by the Registrant due to his misunderstanding of the requirements, was not so serious as to be considered deplorable by fellow practitioners. The Committee found that the conduct in Allegation 10.4 did not amount to misconduct.

Allegation 12.1

238. This Allegation was related to Allegations 1 and 2.1. The Committee had found that Person C had been inexperienced, instructed to act beyond her competence when told to supply patients with medications when there was no pharmacist on the premises and that this had not amounted to the safe and effective delivery of services in the Pharmacy. There had been inadequate supervision of Person C and inadequate checking of prescriptions and medications before they were supplied to patients in the Registrant's absence, as well as no pharmacist available to deal with patient queries.

239. The Committee was satisfied there had been a breach of Standards 1, 5 and 9. The Registrant had failed to provide person centred care as he had not made patients his first priority because he was not available to provide advice to them or intervene if required. He had therefore potentially put patients at risk of harm although the Committee accepted there was no evidence of actual patient harm. He had also failed to use his professional judgement as he had not been in the Pharmacy to access the PMR and check medications properly before they were given to patients.

He had failed to demonstrate leadership because he had failed to lead by example by ensuring the safe and effective delivery of services in the Pharmacy.

240. The Committee was satisfied that this was serious conduct which fell far short of what was expected in the circumstances and fellow practitioners would find it deplorable. The Committee found this amounted to misconduct in relation to Allegation 12.1.

241. **The Committee found Allegations 1, 2, 3, 4 and 12.1 amounted to misconduct.**

Decision on Impairment

242. Having found that Allegations 1, 2, 3, 4 and 12.1 amounted to misconduct, the Committee went on to consider whether the Registrant's fitness to practise is currently impaired. In doing so the Committee considered Rule 5(2) of the Rules and whether the Particulars found proved showed that the actions of the Registrant:

(a) present an actual or potential risk to patients or to the public
(b) has brought, or might bring, the profession of pharmacy into disrepute
(c) has breached one of the fundamental principles of the profession of pharmacy
(d) means that the integrity of the Registrant can no longer be relied upon.

243. The Committee was satisfied that Rules 5(2)(a), (b) and (c) were engaged in this case. Dealing firstly with Rule 5(2)(a), whilst there was no evidence of patient harm, there had been a potential risk of harm to patients. The Committee had found numerous failures – the Registrant had not ensured the safe and effective delivery of services in the Pharmacy, he had failed on at least one occasion to secure the safe custody of CDs, he had allowed a patient to take home medication which should have been supervised consumption and there were numerous occasions of failing to respect and maintain patients' privacy and confidentiality, as well as allowing unqualified staff to supply patients with prescription only and pharmacy medications when there was no pharmacist on the premises or when those medications had not been properly checked first. These all had the potential to place patients at risk of harm.

244. In relation to Rule 5(2)(b), the Registrant's conduct has brought the profession of pharmacy into disrepute. There was no doubt that the public would be shocked and appalled to learn of the Registrant's misconduct which had failed to make the care of patients the Registrant's first priority. His conduct in managing the Pharmacy had fallen far short in many respects. It had taken place over a number of months and was wide-ranging. This undermines public confidence in the pharmacy profession.

245. Finally, in relation to Rule 5(2)(c), the Registrant had breached the fundamental principles of the profession of pharmacy. He had failed to protect, promote and maintain the health, safety and wellbeing of the public, namely patients who trusted him to properly safeguard, administer, supervise and check medications before they were supplied to patients, be available to deal with queries or concerns about medications and keep their personal confidential data stored securely. He had failed to maintain public confidence in the profession and uphold expected standards of behaviour. The Committee heard evidence from Person C that as this was her first job in a pharmacy, and as she had not been aware of the proper procedures and processes that should have been followed, she had just done what the Registrant told her to do. The Registrant had failed to promote and maintain proper professional standards and conduct for members of the profession by breaching Standards 1, 5, 6, 7 and 9 as well as regulations that were in place to protect the public.

246. The Committee then considered whether:

- the conduct which led to the complaints is able to be addressed
- the conduct which led to the complaints has been addressed
- the conduct which led to the complaints is likely to be repeated
- a finding of impairment is needed to declare and uphold proper standards of behaviour and/or maintain public confidence in the profession.

247. The Committee was satisfied that the conduct found proved could be addressed, and the Registrant had taken significant steps to address it. When these concerns were initially raised with him in August 2019, he had immediately resigned from all roles at

the Pharmacy and had not worked there again in any capacity. The Registrant had also attended a number of relevant courses recently on:

- Professional Boundaries for Clinicians
- Professionalism and the Professional Standards for Pharmacists
- How to Ensure a similar Mistake or Misconduct will not be repeated in Future
- The General Data Protection Regulation (2024)

248. The Registrant had provided detailed reflections in his witness statement, copies of his 'CPD planned learning forms' which addressed what he had learnt from the courses and referred specifically to how he had applied this to each of the Standards. A large number of good testimonials had also been provided.

249. The Committee took into account the oral evidence the Registrant had given and his acceptance of his failings, his acknowledgment of his shortcomings and the remorse he had expressed. It was clear to the Committee that the Registrant had thought deeply about what had happened, he had shown insight into why things had gone wrong and had spoken about what he would do differently now. He understood that he had taken on too much too quickly when agreeing to run the Pharmacy at such an early stage of his career. He had accepted his naivety, that there had been "bad practice" and "bad habits" in place, that he had "badly managed" and that he "ran the Pharmacy using WhatsApp which was not a good way to do things". He said that he had shown "bad judgement" and "made mistakes where I shouldn't have allowed things to happen". He had stressed that he now understood he must "remain within the rules" and whilst some things had not been clear to him at the time, he now understood them having read and discussed matters with colleagues.

250. The Committee concluded the Registrant had shown genuine insight, remorse and regret. He now appreciated the importance of the trust placed in pharmacists by the public and referred in his witness statement to his "shame" and "guilt" about what had happened. It was clear that he had learnt a very salutary lesson from these events. Although the Registrant had not acted as a SI since the events complained of, he had been working regularly as a locum RP in various pharmacies. The Committee

was satisfied that he had addressed the conduct complained of and it was unlikely his conduct would be repeated. The Committee concluded that the risk of repetition is low.

251. However, the Committee considered carefully whether it was in the public interest to make a finding of impairment. The Registrant's misconduct was serious, wide-ranging and had taken place over a number of months, potentially exposing patients to a risk of harm. The public expects pharmacists to comply with the rules and regulations in place, and to comply with fundamental principles of the pharmacy profession such as ensuring confidential patient data and CDs are safeguarded, and there is safe and effective delivery of services in the pharmacy with the care of patients at the heart of decision making.

252. The Committee concluded that a finding of impairment is necessary to mark the seriousness of the Registrant's misconduct, to uphold professional standards and to maintain public confidence in the profession and in the regulator. A finding of impairment also promotes professional standards by making clear to other professionals what is expected of them and deterring them from failing to meet those standards.

253. The Committee concluded that it was in the public interest to find that the Registrant's fitness to practise remains currently impaired. The Committee then went on to consider the issue of sanction.

Decision on Sanction

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

255. 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 in the profession and to promote professional standards. The Committee is therefore entitled to give greater weight to the public interest over the Registrant's interests.

256. The Committee had regard to the Council's '*Good decision making: Fitness to practise hearings and outcomes guidance'* (March 2024) to inform its decision and the '*Good decision-making: Conditions bank and guidance'* (July 2023).

257. The Committee took into account the submissions made by both parties, the documents provided and the evidence it had heard.

258. Mr Geering submitted that a suspension of 6 months, or up to 6 months, was the appropriate sanction in this case. He submitted this would mark the significant breaches and maintain confidence in the profession.

259. Mr McCartney reminded the Committee that the purpose of sanction was to meet the regulatory objective of maintaining public confidence in the profession and maintain standards of behaviour. He noted that the Committee had found no risk to the public. He submitted that the Committee could mark the profession's disapproval while reflecting the full context of what it had observed of the Registrant's attitude, behaviour, remorse, insight and his remediation. Mr McCartney accepted that if the Committee concluded a warning was insufficient in this case, conditions would not be appropriate in light of the Committee's decision on impairment. He submitted that if a suspension was to be imposed, the Committee should also take into account the financial impact on the Registrant of being unable to work in the profession. He submitted the suspension could be substantially shorter than 6 months taking into account proportionality.

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

261. The Committee identified the following aggravating factors, including:

a. The misconduct had taken place over a number of months.

b. The breaches were serious and wide-ranging, demonstrating multiple examples of poor pharmacy practises.

c. In relation to allowing prescription only/pharmacy medication to be supplied to patients where there was no pharmacist on the premises, the breaches had been repeated many times over a period of just under 3 months.

d. A number of the breaches had involved Controlled Drugs.

e. The private personal and medication data of numerous patients had been stored on the personal device of a staff member for a number of months, including after that staff member had left the Pharmacy.

262. The Committee identified the following mitigating factors:

a. The Registrant had taken immediate action by removing himself from all roles at the Pharmacy, once concerns had been raised with him.

b. The events complained of had taken place 5 years ago.

c. There was no evidence of harm to patients.

d. There were no previous findings but the Committee balanced this with the fact that the Registrant had been at an early stage of his career at the material time.

e. The Registrant had accepted his failings.

f. He had taken significant steps to remediate and address the concerns, undertaking relevant CPD courses and providing comprehensive reflections.

g. The Registrant had shown genuine insight, expressed remorse and regret.

h. He had co-operated with the regulator and engaged fully with these proceedings.

i. Excellent testimonials had been provided, some of which were from colleagues including pharmacy professionals who had worked with him since these events had taken place.

263. The Committee then considered each of the sanctions in ascending order. The Registrant's misconduct was serious. There had been multiple failures across his pharmacy practise over a number of months, including GDPR breaches and allowing unqualified staff to supply patients with prescription only/pharmacy medications when there was no pharmacist on the premises, or when those medications had not been properly checked first. The Committee concluded that taking no action or issuing a warning to the Registrant would be insufficient to mark the seriousness of the misconduct.

264. The Committee then considered whether to impose conditions on the Registrant's practise. The Registrant had already taken significant steps to remediate the misconduct, had shown genuine insight and remorse, and the Committee had been satisfied there was no risk to patients. The testimonials also confirmed that the Registrant had been working well as a locum since these events. The Committee concluded conditions were not an appropriate sanction in this case.

265. The Committee next considered whether suspension would be a proportionate sanction. The Committee noted the Council's guidance which indicates that suspension may be appropriate:

> "*When it is necessary to highlight to the profession and to the public that the conduct of the professional is unacceptable and unbefitting a member of the pharmacy profession. Also, when public confidence in the profession demands no lesser outcome.*"

266. The Committee had determined this was a serious misconduct case. He had not ensured the safe and effective delivery of services in the Pharmacy, he had failed on at least one occasion to secure the safe custody of CDs, he had allowed a patient to take home CD medication which should have been supervised consumption and there were numerous occasions of failing to respect and maintain patients' privacy and confidentiality, as well as allowing unqualified staff to supply patients with

prescription only/pharmacy medications, including on three occasions CDs, which had not been properly checked and/or while there was no pharmacist on the premises. These had all had the potential to place patients at risk of harm. Particularly serious was the Registrant's failure to keep the personal confidential data of numerous patients stored securely.

267. Whilst the Committee was satisfied there was no evidence of patient harm and no risk to the public, the Registrant had failed to maintain public confidence in the profession and uphold expected standards of behaviour. Members of the public would be shocked and appalled by the Registrant's behaviour. The Committee concluded that a Suspension Order is the appropriate and proportionate sanction in this case. This is the minimum necessary to mark the seriousness of the Registrant's failings, maintain public trust and confidence in the profession and uphold proper standards of conduct for pharmacy professionals.

268. In relation to the period of suspension, the Committee took into account the various mitigating factors and was mindful of the financial impact on the Registrant of not being able to work in pharmacy for a period of time. However, it is important to make it clear to the profession and to the public that this type of conduct is not acceptable. Being inexperienced and naïve is no excuse for taking on the responsibilities of running a pharmacy and then not meeting the Standards and regulations that are in place to safeguard CDs, confidential patient data and ensure the safe and effective delivery of pharmacy services. The Committee concluded that a period of 5 months suspension is appropriate and proportionate. This sends a message to other pharmacy professionals of the conduct expected from pharmacists.

269. As the Registrant had remediated his conduct, shown genuine insight, remorse and had been working well as a locum since these events, the Committee did not consider it was necessary for the Suspension Order to be reviewed at the end of the 5 months period.

270. For the same reasons, the Committee considered removal from the Register would be a disproportionate sanction. The testimonials indicated the Registrant had been performing well at work and it was not in the public interest to deprive the public of

the services of a good pharmacist. In this particular case, public confidence in the profession and the maintenance of proper professional standards and conduct for pharmacy professionals does not require removal.

271. The Committee therefore directs that the Registrar Suspends the Registrant's registration from the Register for a period of 5 months.

272. This concludes the determination.