General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote videolink hearing

1-12 July 2024

Registrant name:	Naureen Amirali WALJI
Registration number:	2066151
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Manuela Grayson (Chair) Sima Hassan (Registrant member) Wendy Golding (Lay member) on 1 July 2022; thereafter, Paul Barton (Lay member)
Committee Secretary:	Zainab Mohamad (1-3 July); Sameen Ahmed (8-12 July)
Registrant:	Present and represented by Wendy Hewitt
General Pharmaceutical Council:	Represented by Alecsandra Manning-Rees, Case Presenter
Facts proved:	5, 16, 17, 23
Facts proved by admission:	1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22
Facts not proved:	None
Fitness to practise:	Impaired

Outcome: Removal

Interim Measures: Interim suspension

This decision including any finding of facts, impairment and sanction is an appealable decision under *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010*. Therefore, this decision will not take effect until 14 August or, if an appeal is lodged, once that appeal has been concluded. However, the interim suspension set out in the decision takes effect immediately and will lapse when the decision takes effect or once any appeal is concluded.

Particulars of Allegation (as amended)

"You a registered pharmacist,

1. Whilst working for UK Meds Direct Ltd between approximately November 2018 and September 2019, you prescribed and/or approved approximately 35,824 prescriptions for high-risk medicines and/or medicines requiring ongoing monitoring.
   [ACCEPTED]

2. In relation to 1 above, you failed to prescribe medicines in accordance with and/or pay due regard to the relevant guidance on prescribing from the General Medical Council ("GMC"), the Royal Pharmaceutical Society ("RPS") and/or the General Pharmaceutical Council ("GPhC") in that you prescribed in circumstances where you:

   2.1 failed to obtain adequate information in relation to the patients' health in advance of prescribing;
   2.2 relied principally on the information received in an online questionnaire;
   2.3 failed to access and/or attempt to access patients' General Practitioner ("GP") medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

2.4 failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;

2.5 failed to adequately consider the possibility of medication dependence and misuse;

2.6 failed to refer patients back to their GP for appropriate assessment and/or review and/or monitoring;

2.7 failed to put adequate safety-netting in place.

[ACCEPTED]

3. In relation to 1 above, you prescribed in circumstances where the UK Meds Direct Ltd prescribing model or service was incapable of supporting safe prescribing decisions in that:

3.1 no face-to-face or other virtual consultation took place other than the use of a questionnaire;

3.2 patients were allowed to pre-select the medicine, strength, and quantity they desired;

3.3 patients provided information primarily through a questionnaire;

3.4 the questionnaire at 3.1 above could be easily manipulated by patients as it highlighted to them answers which could prevent the supply of the medication they desired and permit the patient to change their answer.

[ACCEPTED]

4. In relation to 1 above, you prescribed at such a rate that on most or all occasions that you prescribed, you had insufficient time to clinically evaluate the suitability of the medicines to the patient including:

4.1 read, consider and assimilate the completed questionnaire;

4.2 consider if it was clinically necessary to check with the patients' GP and/or contact the GP;

4.3 consider if it was clinically necessary to contact the patient and/or conduct a face-to-face consultation with the patient;

4.4 consider if it was necessary to check the clinical background of the patient and/or check the clinical background;

4.5 consider the steps you ought to take to prescribe in accordance with UK prescribing guidance as set out at 2 above.

[ACCEPTED]

5. In relation to 1 above, on all or some of the dates and orders outlined in Schedule A, you approved a prescription in circumstances where the time taken (less than a minute) would not have allowed you to properly read through the patient completed questionnaire.

   [Partially ACCEPTED in that the Registrant had assessed each questionnaire request for medication before approving the prescriptions in batches]

6. In relation to 1 above, on all or some of the occasions set out in Schedule B you prescribed high risk medicines to the patients outlined in that schedule in circumstances where you knew or should have known that the patients had already made repeated orders for high-risk medicines and/or prescription only medications from UK Meds Direct Ltd.

   [ACCEPTED]

7. In relation to 1 above, on 21 May 2019 and/or 8 August 2019, you prescribed 100 tablets of Dihydrocodeine 30mg to Patient 3, a patient with a history of opioid dependence, in circumstances where you:

   7.1. knew or should have known that the patient had already made previous and/or repeated orders for the same medicine from UK Meds Direct Ltd;
   7.2. failed to obtain adequate information in relation to the patient's health in advance of prescribing;
   7.3. relied principally on the information received in an online questionnaire;
   7.4. failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;
   7.5. failed to request a face-to-face consultation with the patient in order to adequately examine the clinical need for medication;
   7.6. failed to adequately consider the possibility of medication dependence and misuse;
   7.7. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring;
   7.8. failed to put adequate safety-netting in place.

   [ACCEPTED]

8. In relation to 1 above, on 20 May 2019 you prescribed 100 tablets of Dihydrocodeine 30mg to Patient 4, a patient with a history of opioid dependence, overdose and/or suicidal thoughts, in circumstances where you:

   8.1. knew or should have known that the patient had already made previous and/or repeated orders for the same medicine from UK Meds Direct Ltd;
   8.2. failed to obtain adequate information in relation to the patient's health in advance of prescribing;
   8.3. relied principally on the information received in an online questionnaire;
   8.4. failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;
   8.5. failed to request a face-to-face consultation with the patient in order to adequately examine the clinical need for medication;
   8.6. failed to adequately consider the possibility of medication dependence and misuse;
   8.7. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring;
   8.8. failed to put adequate safety-netting in place.

   [ACCEPTED]

9. On 17 December 2018 you prescribed 84 tablets of Ibuprofen 600mg to Patient 5, a 16 year old girl, a patient with a history of poor mental health, overdose and/or self harm, in circumstances where you:

   9.1. failed to verify her age;
   9.2. failed to obtain adequate information in relation to the patient's health in advance of prescribing;
   9.3. relied principally on the information received in an online questionnaire;
   9.4. failed to access and/or attempt to access the patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

9.5. failed to request a face-to-face consultation with the patient in order to adequately examine the clinical need for medication;

9.6. failed to adequately consider the possibility of medication dependence and misuse;

9.7. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring;

9.8. failed to put adequate safety-netting in place.

[ACCEPTED]

10. In relation to 1 above, on 10 January 2019 and/or 25 April 2019 you prescribed 100 tablets of Dihydrocodeine 30mg to Patient 10, in circumstances where you:

10.1 knew or should have known that the patient had already made previous and/or repeated orders for the same medicine from UK Meds Direct Ltd;

10.2 failed to obtain adequate information in relation to the patient's health in advance of prescribing;

10.3 relied principally on the information received in an online questionnaire;

10.4 failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

10.5 failed to request a face-to-face consultation with the patient in order to adequately examine the clinical need for medication;

10.6 failed to adequately consider the possibility of medication dependence and misuse;

10.7 failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring;

10.8 failed to put adequate safety-netting in place.

[ACCEPTED]

11. In relation to 1 above, on 10 December 2018 you prescribed 56 tablets of Amitriptyline 25 mg to Patient 16, a patient with a history of poor mental health, overdose and/or self harm, in circumstances where you:

11.1 knew or should have known that the patient had already made previous and/or

repeated orders for the same medicine from UK Meds Direct Ltd;

11.2 failed to obtain adequate information in relation to the patient's health in advance of prescribing;

11.3 relied principally on the information received in an online questionnaire;

11.4 failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

11.5 failed to request a face-to-face consultation with the patient in order to adequately examine the clinical need for medication;

11.6 failed to adequately consider the possibility of medication dependence and misuse;

11.7 failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring;

11.8 failed to put adequate safety-netting in place.

[ACCEPTED]

12 Whilst working for MedsOnline 247 between approximately 20 January 2020 and 26 February 2020 you prescribed and/or approved approximately 199 prescriptions including for high-risk medicines and/or medicines requiring ongoing monitoring.

[ACCEPTED]

13 In relation to 12 above, you failed to prescribe medicines in accordance with and/or pay due regard to the relevant guidance from the GMC, the RPS and the GPhC in that you routinely prescribed high risk medicines, in circumstances where you:

13.1 failed to obtain adequate information in relation to the patient's health in advance of prescribing;

13.2 failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

13.3 failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;

13.4 failed to adequately consider the possibility of medication dependence and misuse

13.5 failed to refer patient's back to their GP for appropriate assessment and/or review and/or monitoring;

13.6 failed to put adequate safety-netting in place.

[ACCEPTED]

14 In relation to 12 above on 22 January 2020, you prescribed 100 tablets of Dihydrocodeine 30mg to Patient A, and you:

14.1 failed to obtain adequate information in relation to the patient's health in advance of prescribing;

14.2 failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

14.3 failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;

14.4 failed to adequately consider the possibility of medication dependence and misuse;

14.5 failed to put adequate safety-netting in place.

[ACCEPTED]

15 In relation to 12 above, on 7 February 2020, you prescribed 200 tablets of Co-codamol 30 mg/500mg to Patient B in circumstances where having sufficient knowledge that the patient's GP had refused to prescribe you:

15.1 failed to consult the patient's GP to understand why they had refused a prescription for this medicine to the patient;

15.2 failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

15.3 failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;

15.4 failed to adequately consider the possibility of medication dependence and misuse;

15.5 failed to put adequate safety-netting in place.

[ACCEPTED]

16 In relation to 12 above, on or around 26 February 2020 you emailed to GPhC, a document purporting to be contemporaneous records of consultations including for Patient C who was prescribed codeine on 25 February 2020.

[Partially ACCEPTED in that the document was made later but it consisted of contemporaneous records which the Registrant had made]

17 Your conduct at 16 above was dishonest in that:

17.1 you knew it was not a contemporaneous record because the contemporaneous record you emailed to the pharmacy owner on 25 February 2020 stated only "*Please authorise codeine 30mg x 100 per 6 weeks. Patient has tried tramadol but it does not work. Phone consultation complete Naureen Walji.*"

17.2 you knew that the note you sent included details which would suggest you had recorded a fuller clinical rationale for prescribing a high-risk medicine than the one you relied on to issue the prescription.

[DENIED]

18 Whilst working for Medexpress/Pharmica between approximately 1 March 2022 and 31 May 2022 you prescribed and/or approved approximately 16,140 prescriptions including for medicines requiring ongoing monitoring.

[ACCEPTED]

19 In relation to 18 above, you failed to prescribe medicines in accordance with and/or pay due regard to the relevant guidance from the GMC, the RPS and the GPHC in that you routinely prescribed high risk medicines in circumstances where you:

19.1 failed to obtain adequate information in relation to the patient's health in advance of prescribing;

19.2 relied principally on the information received in an online questionnaire;

19.3 failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

19.4 failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;

19.5 failed to adequately consider the possibility of medication dependence and misuse;

19.6 failed to refer patient's back to their GP for appropriate assessment and/or review and/or monitoring;

19.7 failed to put adequate safety-netting in place.

[ACCEPTED]

20 In relation to 18 above, you prescribed at such a rate that on most or all occasions that you prescribed, you had insufficient time to clinically evaluate the suitability of the medicines to the patient including but not limited to:

20.1 read and consider the questionnaire;

20.2 check with the patient's GP;

20.3 conduct a face-to-face consultation with the patient;

20.4 check the clinical background of the patient;

20.5 consider the steps you ought to take to prescribe in accordance with UK prescribing guidance as set out at 19 above.

[ACCEPTED]

21 In relation to 18 above, on or around 5 April 2022 you prescribed 2 Ventolin (Salbutamol) inhalers for the purpose of asthma treatment to Patient D with no asthma diagnosis and:

21.1 failed to obtain adequate information in relation to the patient's health in advance of prescribing;

21.2 relied principally on the information received in an online questionnaire;

21.3 failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

21.4 failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;

21.5 failed to adequately consider the possibility of medication dependence and misuse;

21.6 failed to put adequate safety-netting in place.

[ACCEPTED]

22 Your approach to prescribing in all or some of the allegations 1 to 21 was transactional in that you were processing patient requests by reference to a patient completed questionnaire rather than prescribing in accordance with UK prescribing guidance.

[ACCEPTED]

23 Your approach to prescribing in all or some of allegations 1 to 15 and 18 to 22 lacked integrity in that you placed financial gain and/or an eagerness to please your employer over and above patient safety.

[Partially ACCEPTED however the Registrant DENIED that her approach to prescribing lacked integrity in that she placed financial gain over and above patient safety]

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

Schedule A – prescriptions approved in less than one minute
On 9 December 2018 at 1929 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 125458.
On 9 December 2018 at 1929 hours, you approved a prescription for Co-codamol-30/500mg - 100 tablets for patient with customer ID 138399.
On 9 December 2018 at 1930 hours, you approved a prescription for Modafinil (Generic)-100mg – 30 tablets for patient with customer ID 172427.
On 9 December 2018 at 1930 hours, you approved a prescription for Dihyrdocodeine-30mg - 100 tablets for patient with customer ID 7083.
On 9 December 2018 at 1930 hours, you approved a prescription for Zopiclone-7.5mg – 7 tablets for patient with customer ID 95545.
On 9 December 2018 at 1931 hours, you approved a prescription for Gabapentin-300mg – 100 capsules for patient with customer ID 63198.
On 9 December 2018 at 1931 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 284438.
On 9 December 2018 at 1931 hours, you approved a prescription for Codeine-30mg – 100 tablets for patient with customer ID 26798.
On 9 December 2018 at 1931 hours, you approved a prescription for Codeine-30mg – 100 tablets for patient with customer ID 19357. On 9 December 2018 at 1932 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 14738.

On 9 December 2018 at 1932 hours, you approved a prescription for Modafinil (Generic)-200mg – 30 tablets for patient with customer ID 96892.
On 9 December 2018 at 1932 hours, you approved a prescription for Zolpidem (Ambien)-10mg – 14 tablets for patient with customer ID 114068.
On 9 December 2018 at 1933 hours, you approved a prescription for Finastride-1mg – 28 tablets for patient with customer ID 74366.
On 9 December 2018 at 1933 hours, you approved a prescription for Ventolin – 2 inhalers for patient with customer ID 26790.
On 9 December 2018 at 1933 hours, you approved a prescription for Co-codamol-30/500mg – 200 tablets for patient with customer ID 37324.
On 9 December 2018 at 1933 hours, you approved a prescription for Zopiclone-3.75mg – 14 tablets for patient with customer ID 23909.
On 9 December 2018 at 1934 hours, you approved a prescription for Modafinil (Generic)-200mg – 10 tablets for patient with customer ID 172439.
On 9 December 2018 at 1935 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 41000.
On 9 December 2018 at 1935 hours, you approved a prescription for Testogel-88g Gel (pump) for patient with customer ID 172443.
On 9 December 2018 at 1935 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 75612.
On 9 December 2018 at 1935 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 128588.

On 9 December 2018 at 1936 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 11356.
On 9 December 2018 at 1936 hours, you approved a prescription for Kapake-30/500mg – 200 tablets for patient with customer ID 65275.
On 9 December 2018 at 1936 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 155985.
On 9 December 2018 at 1936 hours, you approved a prescription for Zolpidem (Ambien)-10mg – 14 tablets for patient with customer ID 4094.
On 9 December 2018 at 1936 hours, you approved a prescription for Naproxen-250mg – 112 tablets for patient with customer ID 105060.
On 9 December 2018 at 1937 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 12824.
On 9 December 2018 at 1937 hours, you approved a prescription for Zolpidem (Ambien)-10mg – 14 tablets for patient with Customer ID 152126.
On 9 December 2018 at 1949 hours, you approved a prescription for Duloxetine-30mg - 56 capsules for patient with Customer ID 172464.
On 9 December 2018 at 1950 hours, you approved a prescription for Pregabalin-150mg – 56 tablets for patient with customer ID 140955.
On 9 December 2018 at 1950 hours, you approved a prescription for Ventolin – 2 inhalers for patient with customer ID 152999.

On 9 December 2018 at 1950 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 42301.
On 9 December 2018 at 1950 hours, you approved a prescription for Modafinil (Generic)-200mg – 30 tablets for patient with customer ID 170558.
On 9 December 2018 at 1951 hours, you approved a prescription for Amitriptyline-10mg – 84 tablets and Cerazette-75mcg – 84 tablets for patient with customer ID 156146.
On 9 December 2018 at 1951 hours, you approved a prescription for Zopiclone-3.75mg – 7 tablets for patient with customer ID 172472.
On 9 December 2018 at 1951 hours, you approved a prescription for Co-codamol-30/500mg – 100 tablets for patient with customer ID 114092.
On 1 January 2019 at 0201 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 69739.
On 1 January 2019 at 0202 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 61106.
On 1 January 2019 at 0202 hours, you approved a prescription for Co-codamol-30/500mg – 200 tablets for patient with customer ID 23045.
On 1 January 2019 at 0202 hours, you approved a prescription for Domperidone-10mg – 30 tablets for patient with customer ID 169016.
On 1 January 2019 at 0203 hours, you approved a prescription for Finastride-1mg – 168 tablets for patient with customer ID 16430.

On 1 January 2019 at 0203 hours, you approved a prescription for Pregabalin-150mg – 56 Capsules for patient with customer ID 132667.
On 1 January 2019 at 0203 hours, you approved a prescription for Cialis (Tadalafil) Generic-20mg – 12 tablets for with customer ID patient 96724.
On 1 January 2019 at 0203 hours, you approved a prescription for Pregabalin-150mg – 56 Capsules for patient with customer ID 171322.
On 1 January 2019 at 0204 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 68847.
On 1 January 2019 at 0204 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 8927.
On 1 January 2019 at 0204 hours, you approved a prescription for Omeprazole-40mg – 28 tablets for patient with customer ID 557313.
On 1 January 2019 at 0204 hours, you approved a prescription for Codeine-30mg – 100 tablets for patient with customer ID 145469.
On 1 January 2019 at 0205 hours, you approved a prescription for Lisinopril-10mg – 84 tablets for patient with customer ID 174903.
On 1 January 2019 at 0205 hours, you approved a prescription for Codeine-30mg – 100 tablets for patient with customer ID 51534.
On 1 January 2019 at 0206 hours, you approved a prescription for Zapain-30/500mg – 100 Caplets for patient with customer ID 81324.

On 1 January 2019 at 0207 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 140705.
On 1 January 2019 at 0207 hours, you approved a prescription for Modafinil (Generic)-200mg – 30 tablets for patient with customer ID 114502.
On 1 January 2019 at 0208 hours, you approved a prescription for Codeine-30mg – 100 tablets for patient with customer ID 66738.
On 11 March 2019 at 0957 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 185536.
On 11 March 2019 at 0957 hours, you approved a prescription for Propranolol-40mg – 84 tablets for patient with customer ID 182511.
On 11 March 2019 at 0957 hours, you approved a prescription for Zolpidem (Ambien)-5mg – 28 tablets for patient with customer ID 172254.
On 11 March 2019 at 0958 hours, you approved a prescription for Zolpidem (Ambien)-5mg – 28 tablets for patient with customer ID 58238.
On 11 March 2019 at 0958 hours, you approved a prescription for Aciclovir (Genital Herpes)-400mg – 15 tablets for patient with customer ID 185563.
On 11 March 2019 at 0959 hours, you approved a prescription for Zolpidem (Ambien)-5mg – 28 tablets for patient with customer ID 155259.
On 11 March 2019 at 0959 hours, you approved a prescription for Codeine-30mg – 100 tablets for patient with customer ID 78106.

On 11 March 2019 at 0959 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 48078.
On 11 March 2019 at 0959 hours, you approved a prescription for Metronidazole-400mg – 14 tablets for patient with customer ID 38663.
On 11 March 2019 at 1000 hours, you approved a prescription for Lariam-250mg – 8 tablets for patient with customer ID 172037.
On 11 March 2019 at 1000 hours, you approved a prescription for Zopiclone-7.5mg – 7 tablets for patient with customer ID 59249.
On 11 March 2019 at 1000 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 16500.
On 11 March 2019 at 1000 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 25392.
On 11 March 2019 at 1001 hours, you approved a prescription for Levonelle 1500-1.5mg – 1 tablets for patient with customer ID 185613.
On 11 March 2019 at 1001 hours, you approved a prescription for Zolpidem (Ambien)-5mg – 28 tablets for patient with customer ID 58162.
On 11 March 2019 at 1001 hours, you approved a prescription for Co-codamol-30/500mg – 100 tablets for patient with customer ID 138399.
On 11 March 2019 at 1001 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 771.

On 11 March 2019 at 1002 hours, you approved a prescription for Co-dydramol-10/500mg – 100 tablets for patient with customer ID 114431.
On 11 March 2019 at 1002 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 20818.
On 11 March 2019 at 1002 hours, you approved a prescription for Viagra (Sildenafil)-100mg –4 tablets for patient with customer ID 99008.
On 11 March 2019 at 1003 hours, you approved a prescription for Zopiclone-7.5mg – 7 tablets for patient with customer ID 185630.
On 11 March 2019 at 1003 hours, you approved a prescription for Codeine-30mg – 100 tablets for patient with customer ID 132566.
On 11 March 2019 at 1003 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 39621.
On 11 March 2019 at 1004 hours, you approved a prescription for Viagra (Sildenafil)-50mg – 16 tablets and Cialis (Tadalafil) Generic-10mg – 12 tablets for patient with customer ID 185631.
On 11 March 2019 at 1004 hours, you approved a prescription for Modafinil (Generic)-200mg – 30 tablets for patient with customer ID 21498.
On 11 March 2019 at 1004 hours, you approved a prescription for Codeine-30mg – 100 tablets for patient with customer ID 4243.
On 11 March 2019 at 1004 hours, you approved a prescription for Glucophage SR-750mg – 56 tablets for patient with customer ID 132804.

On 11 March 2019 at 1004 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 103467.
On 11 March 2019 at 1005 hours, you approved a prescription for Modafinil (Generic)-200mg – 30 tablets for patient with customer ID 15372.
On 11 March 2019 at 1005 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 22680.
On 11 March 2019 at 1006 hours, you approved a prescription for Propranolol-40mg – 56 tablets for patient with customer ID 168168.
On 11 March 2019 at 1006 hours, you approved a prescription for Co-codamol-30/500mg – 200 tablets for patient with customer ID 32995.
On 11 March 2019 at 1006 hours, you approved a prescription for Modafinil (Generic)-100mg – 30 tablets for patient with customer ID 183257.
On 11 March 2019 at 1006 hours, you approved a prescription for Codeine-30mg – 100 tablets for patient with customer ID 79268.
On 11 March 2019 at 1006 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 168999.
On 11 March 2019 at 1007 hours, you approved a prescription for Propranolol-40mg – 84 tablets for patient with customer ID 167581.
On 11 March 2019 at 1007 hours, you approved a prescription for Ventolin – 3 inhalers for patient with customer ID 153631.

On 11 March 2019 at 1007 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 8161.
On 11 March 2019 at 1007 hours, you approved a prescription for Codeine-30mg – 100 tablets for patient with customer ID 122162.
On 11 March 2019 at 1008 hours, you approved a prescription for Modafinil (Generic)-200mg – 30 tablets for patient with customer ID 85641.
On 11 March 2019 at 1008 hours, you approved a prescription for Testogel – 1 pump for patient with customer ID 185652.
On 11 March 2019 at 1008 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 75971.
On 11 March 2019 at 1008 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 47698.
On 11 March 2019 at 1008 hours, you approved a prescription for Modafinil (Generic)-200mg – 30 tablets for patient with customer ID 195774.
On 11 March 2019 at 1009 hours, you approved a prescription for Zopiclone-7.5mg – 13 tablets for patient with customer ID 95803.
On 11 March 2019 at 1009 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 20672.
On 11 March 2019 at 1009 hours, you approved a prescription for Zapain-30/500mg – 200 caplets for patient with customer ID 89097.

On 11 March 2019 at 1010 hours, you approved a prescription for Zolpidem (Ambien)-5mg – 28 tablets for patient with customer ID 14915.
On 11 March 2019 at 1011 hours, you approved a prescription for Zolpidem (Ambien)-5mg – 28 tablets for patient with customer ID 133681.
On 11 March 2019 at 1011 hours, you approved a prescription for Co-codamol-30/500mg – 200 tablets for patient with customer ID 556690.
On 11 March 2019 at 1011 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 64902.
On 11 March 2019 at 1012 hours, you approved a prescription for Modafinil (Generic)-200mg – 30 tablets for patient with customer ID 46189.
On 11 March 2019 at 1012 hours, you approved a prescription for Modafinil (Generic)-200mg – 30 tablets for patient with customer ID 172957.
On 11 March 2019 at 1012 hours, you approved a prescription for Azithromycin-500mg – 2 tablets for patient with customer ID 185628.
On 11 March 2019 at 1012 hours, you approved a prescription for Co-codamol-30/500mg – 100 tablets for patient with customer ID 169713.
On 11 March 2019 at 1013 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 130171.
On 11 March 2019 at 1013 hours, you approved a prescription for Zopiclone-3.75mg – 14 tablets for patient with customer ID 8573.

On 11 March 2019 at 1013 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 89750.
On 11 March 2019 at 1014 hours, you approved a prescription for Solpadol-30/500mg – 200 caplets for patient with customer ID 185643.
On 11 March 2019 at 1014 hours, you approved a prescription for Solpadol-30/500mg – 200 caplets for patient with customer ID 24395.
On 11 March 2019 at 1022 hours, you approved a prescription for Cialis (Tadalafil) Generic-10mg – 4 tablets for patient with customer ID 185620.
On 11 March 2019 at 1023 hours, you approved a prescription for Solpadol-30/500mg – 100 caplets for patient with customer ID 138172.
On 11 March 2019 at 1023 hours, you approved a prescription for Zolpidem (Ambien)-5mg – 28 tablets for patient with customer ID 53267.
On 11 March 2019 at 1023 hours, you approved a prescription for Codeine-30mg – 100 tablets for patient with customer ID 42151.
On 11 March 2019 at 1024 hours, you approved a prescription for Pregabalin-150mg – 56 capsules for patient with customer ID 185625.
On 11 March 2019 at 1024 hours, you approved a prescription for Glucophage SR-500mg – 56 capsules for patient with customer ID 181413.
On 11 March 2019 at 1025 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 41850.

On 11 March 2019 at 1025 hours, you approved a prescription for Dihydrocodein-30mg – 100 tablets for patient with customer ID 135102.
On 11 March 2019 at 1025 hours, you approved a prescription for Metronidazole-400mg – 14 tablets for patient with customer ID 185547.
On 11 March 2019 at 1025 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 6489.
On 11 March 2019 at 1025 hours, you approved a prescription for Salamol-100mcg – 3 inhalers for patient with customer ID 718.
On 11 March 2019 at 1026 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 180417.
On 11 March 2019 at 1026 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 98562.
On 11 March 2019 at 1027 hours, you approved a prescription for Co-codamol-30/500mg – 100 tablets for patient with customer ID 13793.
On 11 March 2019 at 1027 hours, you approved a prescription for Codeine-30mg – 100 tablets for patient with customer ID 47308.
On 11 March 2019 at 1027 hours, you approved a prescription for Finasteride-1mg – 28 tablets for patient with customer ID 45795.
On 11 March 2019 at 1027 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 185653.

On 11 March 2019 at 1932 hours, you approved a prescription for Co-codamol-30/500mg – 200 tablets for patient with customer ID 167098.
On 11 March 2019 at 1932 hours, you approved a prescription for Testogel – 30 sachets for patient with customer ID 185737.
On 11 March 2019 at 1933 hours, you approved a prescription for Zapain-30/500mg – 200 caplets for patient with customer ID 31534.
On 11 March 2019 at 1933 hours, you approved a prescription for Zopiclone-3.75mg – 14 tablets for patient with customer ID 185738.
On 11 March 2019 at 1933 hours, you approved a prescription for Modafinil (Generic)-200mg – 30 tablets for patient with customer ID 143538.
On 11 March 2019 at 1933 hours, you approved a prescription for Zopiclone-3.75mg – 14 tablets for patient with customer ID 20546.
On 11 March 2019 at 1934 hours, you approved a prescription for Naproxen-250mg – 56 tablets for patient with customer ID 165835.
On 11 March 2019 at 1934 hours, you approved a prescription for Cilias (Tadalafil) Generic-20mg – 16 tablets for patient with customer ID 173433.
On 11 March 2019 at 1934 hours, you approved a prescription for Modafinil (Generic)-100mg – 10 tablets for patient with customer ID 185748.
On 11 March 2019 at 1934 hours, you approved a prescription for Co-codamol-30/500mg – 200 tablets for patient with customer ID 75264.

On 11 March 2019 at 1935 hours, you approved a prescription for Testogel – 2 pumps for patient with customer ID 171559.
On 11 March 2019 at 1935 hours, you approved a prescription for Ventolin – 2 inhalers for patient with customer ID 147661.
On 11 March 2019 at 1935 hours, you approved a prescription for Modafinil (Generic)-100mg – 10 tablets for patient with customer ID 191373.
On 11 March 2019 at 1935 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 128635.
On 11 March 2019 at 1935 hours, you approved a prescription for Propranolol-10mg – 56 tablets for patient with customer ID 185416.
On 11 March 2019 at 1936 hours, you approved a prescription for Azithromycin-500mg – 2 tablets for patient with customer ID 185763.
On 11 March 2019 at 1936 hours, you approved a prescription for Evra Patch-6mg/600mcg – 18 patches for patient with customer ID 155597.
On 11 March 2019 at 1936 hours, you approved a prescription for Modafinil (Generic)-200mg – 30 tablets for patient with customer ID 181059.
On 11 March 2019 at 1936 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 97125.
On 11 March 2019 at 1936 hours, you approved a prescription for Testogel – 2 pumps for patient with customer ID 170113.

On 11 March 2019 at 1937 hours, you approved a prescription for Modafinil (Generic)-200mg -30 tablets for patient with customer ID 124253.
On 11 March 2019 at 1937 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 146820.
On 11 March 2019 at 1937 hours, you approved a prescription for Esomeprazole-20mg – 112 capsules for patient with customer ID 144847.
On 11 March 2019 at 1937 hours, you approved a prescription for Azithromycin-500mg – 2 tablets for patient with customer ID 167808.
On 11 March 2019 at 1938 hours, you approved a prescription for Co-codamol-30/500mg – 100 tablets for patient with customer ID 160785.
On 11 March 2019 at 1938 hours, you approved a prescription for Condyline (Genital Warts)-0.5% 3.5ml – 1 bottle for patient with customer ID 185753.
On 11 March 2019 at 1938 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 185754.
On 11 March 2019 at 1938 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 122098.
On 11 March 2019 at 1938 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 185755.
On 11 March 2019 at 1939 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 175281.

On 11 March 2019 at 1939 hours, you approved a prescription for Codeine-30mg – 100 tablets for patient with customer ID 55519.
On 11 March 2019 at 1939 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 62324.
On 11 March 2019 at 1939 hours, you approved a prescription for Finasteride-1mg – 168 tablets for patient with customer ID 65458.
On 11 March 2019 at 1939 hours, you approved a prescription for Codeine-30mg – 100 tablets for patient with customer ID 7408.
On 11 March 2019 at 1940 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 46096.
On 11 March 2019 at 1940 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 131638.
On 11 March 2019 at 1940 hours, you approved a prescription for Zopiclone-3.75mg – 14 tablets for patient with customer ID 108469.
On 17 April 2019 at 0652 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 170612.
On 17 April 2019 at 0652 hours, you approved a prescription for Prpranolol-10mg – 56 tablets for patient with customer ID 6921.
On 17 April 2019 at 0652 hours, you approved a prescription for Zopiclone-3.75mg – 14 tablets for patient with customer ID 110759.

On 17 April 2019 at 0652 hours, you approved a prescription for Co-codamol-30/500mg – 100 tablets for patient with customer ID 7428.
On 17 April 2019 at 0653 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 10336.
On 17 April 2019 at 0653 hours, you approved a prescription for Modafinil-200mg – 30 tablets for patient with customer ID 91941.
On 17 April 2019 at 0654 hours, you approved a prescription for Azithromycin-500mg – 2 tablets and Aciclovir-400mg – 15 tablets for patient with customer ID 181506.
On 17 April 2019 at 0654 hours, you approved a prescription for Dihydrocodeine-30mg – 28 tablets for patient with customer ID 194447.
On 17 April 2019 at 0654 hours, you approved a prescription for Spedra-200mg – 4 tablets and Testogel Pump-16.2mg/g – 1 pump for patient with customer ID 123003.
On 17 April 2019 at 0654 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 493696.
On 17 April 2019 at 0657 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 38390.
On 17 April 2019 at 0657 hours, you approved a prescription for Omeprazole-20mg – 112 capsules for patient with customer ID 110171.
On 17 April 2019 at 0657 hours, you approved a prescription for Kapake-30/500mg – 200 tablets for patient with customer ID 194454.

On 17 April 2019 at 0658 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 66093.
On 17 April 2019 at 0658 hours, you approved a prescription for Codeine-30mg – 100 tablets for patient with customer ID 220304.
On 17 April 2019 at 0658 hours, you approved a prescription for Kapake-30/500mg – 100 tablets for patient with customer ID 70008.
On 17 April 2019 at 0659 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 168344.
On 17 April 2019 at 0659 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 83615.
On 17 April 2019 at 0700 hours, you approved a prescription for Co-codamol-30/500mg – 200 tablets for patient with customer ID 6303.
On 17 April 2019 at 0700 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 31972.
On 17 April 2019 at 0700 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 173333.
On 17 April 2019 at 0701 hours, you approved a prescription for Omeprazole-20mg – 56 capsules for patient with customer ID 154606.
On 17 April 2019 at 0701 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 30968.

On 17 April 2019 at 0701 hours, you approved a prescription for Norethisterone-5mg – 60 tablets for patient with customer ID 194228.
On 17 April 2019 at 0702 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 194439.
On 17 April 2019 at 0702 hours, you approved a prescription for Zopiclone-3.75mg – 14 tablets for patient with customer ID 141714.
On 17 April 2019 at 0702 hours, you approved a prescription for Condyline – 1 bottle for patient with customer ID 194433.
On 17 April 2019 at 0703 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 71786.
On 17 April 2019 at 0703 hours, you approved a prescription for Ventolin-100mcg – 1 inhaler for patient with customer ID 194432.
On 17 April 2019 at 0703 hours, you approved a prescription for Remedeine Forte-30/500mg – 112 tablets for patient with customer ID 6797.
On 17 April 2019 at 0703 hours, you approved a prescription for Zolpidem-5mg – 28 tablets for patient with customer ID 87043.
On 17 April 2019 at 0704 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 3453.
On 17 April 2019 at 0704 hours, you approved a prescription for Kapake-30/500mg – 200 tablets for patient with customer ID 5109.

On 17 April 2019 at 0704 hours, you approved a prescription for Zolipdem-5mg – 28 tablets for patient with customer ID 168360.
On 17 April 2019 at 0705 hours, you approved a prescription for Omeprazole-40mg – 112 capsules for patient with customer ID 351478.
On 17 April 2019 at 0705 hours, you approved a prescription for Modafinil-200mg – 30 tablets for patient with customer ID 190037.
On 17 April 2019 at 0705 hours, you approved a prescription for Modafinil-200mg – 10 tablets for patient with customer ID 10334.
On 17 April 2019 at 0706 hours, you approved a prescription for Treclin Gel – 30g tube for patient with customer ID 194411.
On 17 April 2019 at 0707 hours, you approved a prescription for Metformin-850mg – 112 tablets for patient with customer ID 194420.
On 17 April 2019 at 0707 hours, you approved a prescription for Codeine-30mg – 100 tablets for patient with customer ID 194420.
On 17 April 2019 at 0707 hours, you approved a prescription for Modafinil-200mg – 30 tablets for patient with customer ID 171263.
On 17 April 2019 at 0707 hours, you approved a prescription for Amitriptyline-10mg – 28 tablets for patient with customer ID 194417.
On 17 April 2019 at 0708 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 178474.

On 17 April 2019 at 0708 hours, you approved a prescription for Diclofenac-50mg – 84 tablets for patient with customer ID 177985.
On 14 July 2019 at 0334 hours, you approved a prescription for Cialis (Tadalafil) Generic-20mg – 12 tablets for patient with customer ID 142534.
On 14 July 2019 at 0334 hours, you approved a prescription for Candesartan-16mg – 84 tablets for patient with customer ID 203459.
On 14 July 2019 at 0334 hours, you approved a prescription for Viagra (Sildenafil) Generic-100mg – 4 tablets for patient with customer ID 224982.
On 14 July 2019 at 0335 hours, you approved a prescription for Diclofenac-50mg – 84 tablets for patient with customer ID 224952.
On 14 July 2019 at 0336 hours, you approved a prescription for Finasteride-1mg – 28 tablets for patient with customer ID 223845.
On 14 July 2019 at 0336 hours, you approved a prescription for Propranolol-40mg – 56 tablets for patient with customer ID 132390.
On 14 July 2019 at 0336 hours, you approved a prescription for Cialis (Tadalafil) Generic-2.5mg – 28 tablets for patient with customer ID 225070.
On 14 July 2019 at 0337 hours, you approved a prescription for Viagra (Sildenafil) Generic-50mg – 64 tablets for patient with customer ID 145410.
On 14 July 2019 at 0337 hours, you approved a prescription for Fucidin Cream – 1 tube 30mg for patient with customer ID 224945.

On 14 July 2019 at 0338 hours, you approved a prescription for Dihydrocodeine-30mg– 100 tablets for patient with customer ID 6699.
On 14 July 2019 at 0338 hours, you approved a prescription for Cialis (Tadalafil) Generic-2.5mg – 84 tablets for patient with customer ID 224999.
On 14 July 2019 at 0339 hours, you approved a prescription for Zolpidem-10mg – 14 tablets for patient with customer ID 30090.
On 14 July 2019 at 0339 hours, you approved a prescription for Dihydrocodeine-30mg – 100 tablets for patient with customer ID 97192.
On 14 July 2019 at 0340 hours, you approved a prescription for Metronidazole-400mg – 14 tablets for patient with customer ID 185845.
On 14 July 2019 at 0340 hours, you approved a prescription for Norethisterone-5mg – 60 tablets for patient with customer ID 224916.
On 14 July 2019 at 0341 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 192512.
On 14 July 2019 at 0341 hours, you approved a prescription for Evorel-50mcg – 8 patches for patient with customer ID 224061.
On 14 July 2019 at 0342 hours, you approved a prescription for Viagra (Sildenafil) Generic-100mg – 32 tablets for patient with customer ID 259943.
On 14 July 2019 at 0346 hours, you approved a prescription for Cialis (Tadalafil) Generic-20mg – 16 tablets for patient with customer ID 223710.
On 14 July 2019 at 0347 hours, you approved a prescription for Codeine-30mg – 100 tablets for patient with customer ID 224917.

On 14 July 2019 at 0347 hours, you approved a prescription for Modafinil-200mg – 30 tablets for patient with customer ID 170494.
On 14 July 2019 at 0347 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 224931.
On 14 July 2019 at 0348 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 46581.
On 25 August 2019 at 1801 hours, you approved a prescription for Cialis (Tadalafil) Generic-20mg – 16 tablets for patient with customer ID 243420.
On 25 August 2019 at 1802 hours, you approved a prescription for Acetazolamide-250mg – 56 tablets for patient with customer ID 243810.
On 25 August 2019 at 1804 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 97843.
On 25 August 2019 at 1805 hours, you approved a prescription for Zopiclone-3.75mg – 14 tablets for patient with customer ID 47991.
On 25 August 2019 at 1805 hours, you approved a prescription for Metronidazole-400mg – 14 tablets for patient with customer ID 181460.
On 25 August 2019 at 1806 hours, you approved a prescription for Zopiclone3.75mg – 14 tablets for patient with customer ID 85194.
On 25 August 2019 at 1807 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 15508.
On 25 August 2019 at 1808 hours, you approved a prescription for Testogel Pump-16.6mg/g – 1 pump for patient with customer ID 243821.
On 25 August 2019 at 1808 hours, you approved a prescription for Cialis (Tadalafil) Generic-20mg – 12 tablets for patient with customer ID 243566.
On 25 August 2019 at 1811 hours, you approved a prescription for Modafinil-100mg – 30 tablets for patient with customer ID 83084.

On 25 August 2019 at 1811 hours, you approved a prescription for Zopiclone-3.75mg – 7 tablets for patient with customer ID 163038.
On 25 August 2019 at 1812 hours, you approved a prescription for Zopiclone-7.5mg – 7 tablets for patient with customer ID 243725.
On 25 August 2019 at 1812 hours, you approved a prescription for Azithromycin-500mg – 2 tablets for patient with customer ID 242918.
On 25 August 2019 at 1814 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 68531.
On 25 August 2019 at 1817 hours, you approved a prescription for Zopiclone-7.5mg – 14 tablets for patient with customer ID 97109.

Date (s)	Medicine/quantity	Patient Customer ID/Patient No.
18 November 2018	Codeine-30mg – 100 tablets	39247
22 December 2018	Zolpidem (Ambien)-10mg – 14 tablets	39247
16 January 2019	Propranolol-40mg – 84 tablets	39427
22 January 2019	Codeine-30mg – 100 tablets	39427
16 February 2019	Propranolol-40mg – 84 tablets	39427
21 February 2019	Zolpidem (Ambien)-5mg – 28 tablets	39247
16 July 2019	Codeine-30mg – 100 tablets	39247
28 July 2019	Codeine-30mg – 100 tablets	39247
21 December 2018	Codeine-30mg – 100 tablets	2088
1 March 2019	Codeine-30mg – 100 tablets	2088
13 May 2019	Dihydrocodeine-30mg – 100 tablets	2088
31 May 2019	Codeine-30mg – 100 tablets	2088
19 January 2019	Codeine-30mg – 100 tablets	3024
8 April 2019	Zopiclone-7.5mg – 7 tablets	3024
24 May 2019	Codeine-30mg – 100 tablets	3024
17 November 2018	for Dihydrocodeine-30mg – 100 tablets	260528
10 December 2019	Amitriptyline-25mg – 84 tablets	260528
13 January 2019	Dihydrocodeine-30mg – 100 tablets	260528
1 April 2019	Amitriptyline-25mg – 28 tablets	260528
5 May 2019	Dihydrocodeine-30mg – 100 tablets	260528
5 May 2019	Amitriptyline-25mg – 28 tablets	260528
3 June 2019	Dihydrocodeine-30mg – 100 tablets	260528
3 June 2019	Amitriptyline-25mg – 28 tablets	260528
13 June 2019	Dihydrocodeine-30mg – 100 tablets	260528
2 January 2019	Dihydrocodeine-30mg – 100 tablets	2202
18 February 2019	Dihydrocodeine-30mg – 100 tablets	2202

3 June 2019	Dihydrocodeine-30mg – 100 tablets	2202
12 April 2019	Dihydrocodeine-30mg – 100 tablets	4634
20 May 2019	Dihydrocodeine-30mg – 100 tablets	4634
10 June 2019	Dihydrocodeine-30mg – 100 tablets	4634
26 June 2019	Dihydrocodeine-30mg – 100 tablets	4634
31 December 2018	Dihydrocodeine-30mg – 100 tablets	89573
18 March 2019	Dihydrocodeine-30mg – 100 tablets	89573
30 May 2019	Dihydrocodeine-30mg – 100 tablets	89573

Documentation

Document 1- GPhC hearing bundle: 1574 electronic pages

Document 2- GPhC supplementary bundle: British National Formulary (BNF) guidance: 73 pages

Document 3-GPhC Excel spread sheets: SO/01 and SO/02

Document 3- GPhC Statement of Case and Skeleton Argument: 49 pages

Document 4- Defence Bundle: 134 pages

Document 5- On Day 5 of the hearing the Council provided a new document, namely the Council's Inspection Report of an inspection of Medexpress/Pharmica dated 6 May 2021.

Witnesses

<u>On behalf of the Council:</u>

- Dr C

<u>On behalf of the Registrant:</u>

- The Registrant gave oral evidence in relation to the facts and impairment.

Determination

Introduction

1. This Principal Hearing concerns Naureen Walji ("the Registrant"), a Pharmacist first registered with the Royal Pharmaceutical Society of Great Britain on 30 July 2007 and subsequently transferred to the General Pharmaceutical Council ("the Council") under the registration number 2066151. The Registrant faces an Allegation of impairment of her fitness to practise by reason of misconduct.

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

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

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

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

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

4. The Committee also has regard to the guidance contained in the Council's *Good decision making: Fitness to practise hearings and sanction guidance* (2024).

5. A Principal Hearing has up to three stages:

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

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

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

6. On the first day of the hearing, it was discovered that Ms Golding had sat on a previous panel which had imposed an interim order in respect of the Registrant and therefore under the rules she could not sit as a panel member at this Principal Hearing. She therefore recused herself and the panel reconvened on day 2, 2 July 2024, with Paul Barton as lay member.

Consideration of whether to Amend the Particulars of Allegation

7. Ms Manning-Rees made an application under Rule 41 of the Rules to amend the Particulars of Allegation. There were three typographical errors, namely:
   - In particular 3 the word "Direct" had accidentally been omitted from "UK Meds Direct Ltd";
   - In particular 2.6, the superfluous word "and/or" should be deleted;
   - In particular 20.5, the number "2" should be replaced by "19"; and one error of minor importance, not material to the seriousness of the Allegation as a whole, namely:
   - In particular 23 the numbering at "1-11" should be amended to "1-15".

8. Ms Hewitt on behalf of the Registrant informed the Committee that she did not oppose the proposed amendments.

9. The Committee having considered the proposed amendments was of the view that they made no material difference to the overall gravity of the allegations and they ought to be implemented so as to correct what were clearly typographical errors.

The Registrant's response to the Particulars of Allegation

10. The Registrant accepted particulars 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 18, 19, 20, 21, and 22.

11. She partially accepted particular 5 in that she grouped prescriptions earlier in the day in batches and thus had longer checking them than appeared from the electronic record.

12. The Registrant partially accepted particular 16 in that whilst the document was made later (on the following day), therefore was not contemporaneous, it was an accurate record of a contemporaneous note she had made.

13. The Registrant denied particular 17 in its entirety.

14. The Registrant partially accepted particular 23 in that she denied that her approach to prescribing lacked integrity in that she placed financial gain over and above patient safety.

15. In the light of the above, and by the application of Rule 31(6) of the Rules, the Chair announced that factual particulars 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 18, 19, 20, 21, and 22 were found proved by admission.

16. The Committee went on to receive evidence and submissions regarding the remaining particulars.

Background, as set out in the Council's Statement of Case

17. Ms Manning-Rees, in a detailed Statement of Case and Skeleton Argument, provided the background to the Council's case, including a summary of the Registrant's alleged conduct and the relevant guidelines and rules which, Ms Manning-Rees submitted, the Registrant should have followed. The Council's Background (with amendments by the Committee) is summarised below.

18. The Allegation in this case relates to the Registrant's practice at three separate online pharmacies between 2018 and 2022. Those pharmacies are UK Meds Direct Ltd ('UK Meds'), MedsOnline 247 and Medexpress/Pharmica.

UK Meds Direct Ltd

19. UK Meds began operating in October 2017. The Registrant prescribed for UK Meds between 12 November 2018 and 9 September 2019. The Registrant was engaged as a self-employed, third-party contractor who provided prescribing services on an arms- length basis, whilst being qualified as a pharmacist independent prescriber. The Registrant was not at any time, employed as an employee of UK Meds.

20. UK Meds was an online pharmacy that used Pharmacist Independent Prescribers ('PIPs') to issue prescriptions for patients who had selected their medication from the website and then completed a questionnaire in order to obtain the prescription and purchase the medication privately.

21. UK Meds was inspected on 15 February 2019 and an improvement notice was issued on 29 March 2019. The notice stated that the pharmacy had to make the following improvements to its services:

"*Procedures must be strengthened to ensure that pharmacy services are managed and delivered safely and effectively, and associated risks are identified and managed, in particular:*

a. *Identity checks are strengthened*
b. *Information to be obtained to check the supply of medicines against a prescription is safe and appropriate*
c. *Strengthening procedures to identify and safeguard vulnerable adults and children*
d. *Checks strengthened to identify requests for medicines that are inappropriate, including where there is a higher risk of addiction or abuse procedures are strengthened to ensure the*

professional authorising the supply is aware of whether relevant information about the prescription has been shared with other healthcare professionals, in order to make an informed decision to supply"

22. A further visit was conducted on 14 May 2019. Notes were made by the inspector. The Registrant is recorded as being one of four PIPs who worked remotely. It is recorded that all the PIPs work in other practices and work under contract to UK Meds. PIPs were paid per item, whether the request was approved or not.

23. It is noted that all PIPs have functionality to access the patient medication record (PMR) which had been created in-house. The prescriber was said to be able to see a full history; everything prescribed and history of supplies. Prescribers could not see if patients had changed their responses to a question.

24. The notes recorded that '*In practice, the full request and prescribing history with prescriber interventions or comments was not visible to the checking pharmacist on the same screen or system as the current order. The checking pharmacist has to access this separately*'.

25. The Superintendent Pharmacist ('SI') pointed out that the final decision to prescribe treatment remained with the prescriber.

26. A further inspection was carried out on 3 September 2019 (six days before the Registrant finished working for UK Meds). Not all standards were met, and the inspection report noted that the pharmacy was still not managing the risks associated with supplying high risks drugs online.

27. On 27 September 2019, UK Meds were given another improvement notice, including actions to:

- *Proactively share relevant information about the prescriptions they issue with the patient's healthcare professionals, for example a GP*

- *Prescribers to contact a patient's GP in advance of issuing a prescription to confirm the prescription is appropriate and that appropriate monitoring is in place*
- *Prescribers make clear records of their justifications for prescribing in circumstances where the patient does not have a GP or does not consent to information being shared*

28. As a result of the inspection, conditions were imposed on UK Meds on 8 November 2019 which prohibited it from selling or supplying any controlled drugs from Schedule 1-5 and selling or supplying Modafinil.

29. The conditions imposed were due to the prescribing of opioids, z-drugs and Modafinil not in line with good practice and UK national guidelines. These medicines were being prescribed without any diagnosis from a patient's GP, without input from a patient's GP, with limited amounts of clinical information to ensure supplies were clinically correct.

30. It was also noted that the pharmacy had not provided sufficient evidence that it managed the risk that people may deliberately provide incorrect information to receive medicines that they want, despite it being clinically inappropriate, particularly for people seeking opioids and z-drugs who may have a substance abuse problem.

31. The pharmacy did not contact a patient's GP prior to issuing a prescription to confirm it was an appropriate supply and that appropriate monitoring was in place. Although a letter was sometimes sent to a patient's GP detailing the patient's request, it was insufficient to show good communication and shared care in the patient's best interests because if no response was received within one day, the supply was made anyway.

Expert Evidence of Dr C

32. Dr C provided two expert witness reports for the Council's investigation into UK Meds. She states that: *"the model used by UK Meds Ltd was unsafe insofar as prescribing within the requirements and limits of the framework was not in accordance with the competencies as*

described in the Royal Pharmaceutical Society's Competency Framework".

33. Dr C states that in her opinion, "*…self-populated questionnaires do not give sufficient clinical information to allow for an adequate patient assessment…"* She outlines that a clinician requires access to a patient's medical records or to have a discussion with a patient's GP as well as potential face to face assessment to confirm current physical or mental health by video-link or, at least by discussion over the telephone.

34. Dr C states that patients with ongoing pain require regular face to face assessment in order that their condition is properly examined, and medication is either stopped, changed or optimised.

35. In her opinion, *"…prescribing from a questionnaire without a face to face consultation is not and cannot be in a patient's best interests as the prescriber does not have a full and complete clinical picture of the patient".*

36. Dr C further opines that *"…a prescriber should be aware of potential misuse of all opiates and needs to be aware of any past or current addiction issues (from medical records, rather than self-reported), needs to keep adequate records in order to check frequency of requests and amounts previously supplied*".

37. In her opinion, prescribers not communicating with a patient's GP is unsafe and contrary to national guidelines. A GP should be consulted prior to any prescription being authorised and adequate clinical records sent to the GP after a prescribing episode.

Relevant standards, guidance and competencies

38. The Royal Pharmaceutical Society published "*A competency framework for all Prescribers"* in July 2016. At section 6 of this framework, it sets out ten competencies relevant to what it

terms “good prescribing”. These are divided into two areas, “*The Consultation*” and “*Prescribing Governance*”.

a. *The Consultation*

1. *Assess the patient*
2. *Consider the options*
3. *Reach a shared decision*
4. *Prescribe*
5. *Provide information*
6. *Monitor and review*

- *Prescribing Governance*

7. *Prescribe safely*
8. *Prescribe professionally*
9. *Improve prescribing practice*
10. *Prescribe as part of a team*

39. The framework then sets out the various ways in which a prescribing practitioner can meet the competencies. In relation to 1) Assess the Patient – it lists eight factors which a prescriber should consider when undertaking their assessment of the patient:

1.1 *Takes an appropriate medical, social and medication history including allergies and intolerances.*

1.2 *Undertakes an appropriate clinical assessment.*

1.3 *Accesses and interprets all available and relevant patient records to ensure knowledge of the patient’s management to date.*

1.4 *Requests and interprets relevant investigations necessary to inform treatment options.*

1.5 *Makes, confirms or understands, the working or final diagnosis by systematically*

considering the various possibilities (differential diagnosis).

1.6 *Understands the condition(s) being treated, their natural progression and how to assess their severity, deterioration and anticipated response to treatment.*

1.7 *Reviews adherence to and effectiveness of current medicines.*

1.8 *Refers to or seeks guidance from another member of the team, a specialist or a prescribing information source when necessary*.

40. The Framework as demonstrated by the example above gives a structure for those prescribing medicines to '*consider the patient needs, assessing the risk and benefits of a patient taking or not taking a particular medicine'* (2.3), giving consideration to '*understanding the potential for adverse effects and takes steps to avoid/minimise and manage them'* (4.2) and '*considers the potential for misuse of medicines'* (4.7).

41. Of particular relevance to the case against the Registrant are:

- Section 6 on Monitoring and reviewing prescriptions
- Section 7 on Prescribing safely which at 7.3 states '*Identifies the potential risks associated with prescribing via remote media…and takes steps to minimise them'* and
  7.4 which states: '*Minimises risk to patients by using or developing processes that support safe prescribing particularly in areas of high risk (e.g…prescription of repeat medicines)'*, and
- Section 8 on prescribing professionally which sets out that the prescriber 8.2 '*Accepts personal responsibility for prescribing and understands the legal and ethical implications'*; 8.3 *'knows and works within legal and regulatory frameworks affecting prescribing practice*', 8.4 '*makes prescribing decisions base don't he needs of patients and not the prescriber's personal considerations*' and 8.5 '*Recognises and deals with factors that might unduly influence prescribing'.*

42. Within the glossary section of the framework, it sets out the definition of independent prescribing thus:

"Independent prescribing is prescribing by a practitioner, who is responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing".

43. In addition, to the Framework, the current version of the Standards for Pharmacy Professionals has been in force since May 2017. Whilst not specific to PIPs, it is plainly relevant to the conduct for prescribing pharmacists.

44. Whilst the standards as whole are relevant to this case of particular relevance are:

- Standard 2: Pharmacy professionals must work in partnership with others
- Standard 3: Pharmacy professionals must communicate effectively
- Standard 5: Pharmacy professionals must use their professional judgement

45. The GPhC Guidance for Pharmacist Prescribers published in November 2019 ('the Guidance') is a detailed document setting out what is expected of pharmacist prescribers. Whilst the document was published outside the timeframe for charges 1-11 the GPhC submit that the obligations within that guidance are inherent in any pharmacy prescriber's practice.

46. At page 7, the Guidance states:
"…the prescribing process is complex and is about more than just writing a prescription. However, a PIP is responsible for and accountable for the clinical assessment and management of people (with diagnosed or undiagnosed conditions), without needing to consult another prescriber. They are also responsible for the prescribing decisions they make."

47. Section one of the Guidance deals with "*Taking responsibility for prescribing safely"*:

"People receive safe, effective and person-centred care when pharmacy professionals treat every person as an individual with their own values, need and concerns. Pharmacist prescribers are responsible and accountable for their decisions and actions…Any prescribing decisions must be made in partnership with the person being assessed, to make sure the care meets their needs and that the pharmacist prescriber has consent to prescribe, when this is appropriate"

48. It goes on to state:

"Pharmacist prescribers must use their professional judgement, so that they act in the person's best interests and prescribe only the medicines they know to be safe and effective for the condition they are treating.

Pharmacist prescribers must communicate effectively with the person to:

- *Understand their needs*
- *Make sure there is a genuine clinical need for treatment Assess whether the person has the capacity to make a decision about their care or consent […]*
- *Come to a shared decision about the care they provide […]*
- *Make sure the person is aware of any risks involved in their treatment and the risks of any reasonable alternative or different treatment option"*

49. The Guidance states: *"Pharmacist prescribers must make sure incentives and targets do not compromise their professional judgement. They must make sure the care they provide reflects the needs of the person and does not compromise the health, safety and wellbeing of patients and the public".*

50. The Guidance describes three areas that pharmacy professionals should consider:

- *Having all the necessary information to prescribe safely*
- *Prescribe safely*
- *Follow up*

51. Within the Guidance under the heading "*Having all the necessary information to prescribe safely",* it specifically discusses the risks in being unable to check a person's medical record, something which is a key consideration in remote prescribing. The guidance highlights that there are potential risks in prescribing without records and states:
"Pharmacist prescribers should assess whether they have sufficient information and knowledge of the person's health and medical history to make an assessment of the conditions."

52. This is to ensure that "…*they are able to reduce any risks in deciding whether they can prescribe safely. They should be able to demonstrate that they have assess the risks when making a professional judgement, for example by keeping a record of their reasons to prescribe in these circumstances"*

53. The Guidance highlights that prescribers should assess the risks for *"people seeking medicines or treatment inappropriately*" and *"requests for large quantities of, or frequent requests for, medicines- particularly ones that may be abused, overused or misused and do everything they can to make those risks as low as possible"***.**

54. In relation to 2. *Prescribe safely* it states:

- *Pharmacist prescribers must prescribe only within the limits of their knowledge, skills and area of competence. They should:*
    - *Fully assess the person and carry out an examination […]*
    - *Prescribe in line with clinical, national and local guidelines […]*
    - *When prescribing and reviewing the person's medicines, communicate and document any changes to a person's medical record as soon as possible […]*
    - *Explain their reasons for not prescribing and any other options available to the person when they consider prescribing to be inappropriate […]*
    - *Be able to show that all prescribing arrangements are transparent and that there is no conflict of interest such as:*
    - *[…] making prescribing decisions based on the needs of the person and not because of commercial interests or pressures from people, colleagues, employers or*

pharmaceutical companies

- *Consider the impact of their prescribing on the person they are prescribing for*
- *Consider when it may be appropriate to withhold medicines, deprescribe or alter a prescribed dose*
- *Review prescriptions with repeats*

55. Finally in respect of 3. *Follow up* it states that a pharmacist prescriber should:

- *Plan appropriate follow-up reviews that meet the needs of the person seeking care*
- *Assess and monitor the outcome of the prescribing activity to make sure safe and effective care is provided*
- […]Safety netting

56. Section 3 of the Guidance is titled "working in partnership with other healthcare professionals and people seeking care" in which it states:
"Pharmacists must ask the person for consent to access their medical records, or to get other reliable information about the person's health and medicines form their regular prescriber"

57. The Guidance then gives specific help on what to do in situations where pharmacist prescribers do not have access to a patient's medical records. It states:
The pharmacist prescriber must then decide whether or not to prescribe. They will need to think about the person's best interests, make a risk based assessment about whether they can prescribe safely and make a clear record, setting out their justification for prescribing or not prescribing. Prescribing information should be shared with the person's prescriber, or others involved in their care, so the person received safe and effective care. Pharmacist prescribers should use their professional judgement when deciding what information to share. This is especially important when prescribing medicines that are liable to abuse, overuse or misuse, when there is a risk of addiction or when ongoing monitoring is important ".

58. Section 4 of the Guidance is titled *"Prescribing considerations and clinical judgement".* Section 4.2 highlights that *"In all cases, any decision to prescribe and supply must be made in the*

person's best interests, and the pharmacist prescriber must make sure that the person's health and safety are not compromised…They must also make a record of their prescribing and the reasons for their prescribing decision".

59. Section 4.4 deals with *"online prescribing and safeguards for the online prescribing of certain medicines".* Within this section it states:

"…Pharmacist prescribers must make sure patient safety is not compromised. This is especially important when the person is vulnerable or at risk of addiction to certain medicines. Pharmacist prescribers must make an adequate and safe clinical assessment, communicate effectively and get the person's consent to access their medical record. It is especially important when prescribing at a distance that pharmacist prescribers assess the capacity of the person seeking care. Prescribing medicines at a distance, either as part of an online prescribing service or independently over the internet, brings different risks from those when there is a face- to-face consultation. Certain medicines are not suitable to be prescribed online (for example nonsurgical cosmetic products), and for some medicines there should be extra safeguards in place.

In light of the very real patient safety risks, pharmacist prescribers must not make prescribing decisions for high-risk medicines based mainly on online questionnaires with no access to the person's medical history or consent to contact the person's regular prescriber. (High-risk medicines are, for example, those liable to abuse, overuse or misuse, or when there is a risk of addiction and ongoing monitoring is important.) Appropriate risk management and safeguards must be in place, or the registration of the pharmacist prescriber could be at risk. Pharmacist prescribers are accountable for their prescribing decisions, including when prescribing at a distance. They should prescribe only when they have adequate knowledge of the person's health and their full medical and prescribing history: for example, by using the person's medical records and other sources of information to establish any allergies or interactions. They must be satisfied that the medicines serve the person's needs. Any decisions about treatment are for both the pharmacist prescriber and the person to consider together during the consultation. If the pharmacist prescriber has not carried out a face-to-face consultation with the person, they should explain to the person how the remote consultation will be carried out.

Before prescribing at a distance, pharmacist prescribers should consider:

- *how they can check that the person is who they claim to be, by carrying out an appropriate identity check […]*
- *the limitations on effective communication with the person through the consultation at a distance (for example, not being able to see physical symptoms or read their body language, not being able to ask follow-up questions)*
- *which medicines are appropriate for prescribing and supplying at a distance, including online*
- *whether they can assess if the person has capacity to decide about their medicines*
- *whether a physical examination or other assessment is needed*

- *who the person should contact if they have any questions or want to discuss something*
- *how they identify requests for medicines that are inappropriate – by being able to identify multiple orders to the same address or orders using the same payment details. This includes inappropriate*
- *combinations of medicines and requests that are too large or too frequent*

60. There are also categories of medicines which the Guidance states are not suitable to be prescribed or supplied at a distance unless further safeguards have been put in place to make sure that they are clinically appropriate. Of relevance to this case is:

"medicines liable to abuse, overuse or misuse, or when there is a risk of addiction and ongoing monitoring is important. For example: opioids, sedatives, laxatives, and gabapentinoids".

61. The Guidance goes on to detail that these medicines should only be prescribed, at a distance, if the prescriber has:

- *has robust processes in place to check the identity of the person, to make sure the medicines prescribed go to the right person[…]*
- *has asked the person for the contact details of their regular prescriber, such as their GP, and for their consent to contact them about the prescription*
- *will proactively share all relevant information about the prescription with other health professionals involved in the care of the person (for example their GP)*
- *has contacted the GP in advance of issuing a prescription for medicines which are liable to abuse, overuse or misuse (or where there is a risk of addiction and ongoing monitoring is important) and the GP has confirmed to the prescriber that the prescription is appropriate for the person and that appropriate monitoring is in place*
- *has systems in place for circumstances when the person does not have a regular prescriber such as a GP, or there is no consent to share information, and the pharmacist prescriber has decided, in exceptional circumstances, still to issue a prescription. They should make a clear record setting out their justification for prescribing (for example: how they have kept any risks as low as possible; the*

immediate need; how they have arrived at their decision to prescribe; and the exceptional circumstances)

- *is working within national and local prescribing guidelines for the UK and good practice guidance. This would include following relevant guidance on prescribing a licensed medicine for an unlicensed purpose (called 'off-label' prescribing).*

62. Although this Guidance was published in November 2019, it is the submission of the GPhC that as already highlighted above, other similar guidance was available from the GMC and the Royal Pharmaceutical Society as early as 2013.

The Registrant

63. The investigation into the prescribing practices of the Registrant began after the Council received concerns from healthcare professionals and concerned members of the public regarding the inappropriate supply of medication to their patients and family members from an online pharmacy, UK Meds. This led to a wider investigation into the pharmacy and those who worked for it. The Council also received concerns about the Registrant's prescribing whilst working for other online pharmacies (- Concern re Patient D).

64. Each of these pharmacies employed the Registrant as a PIP. These three pharmacies operated an online dispensing model.

Submissions on the Facts

65. Particulars 1-11 relate to the Registrant's work for UK Meds between November 2018 and September 2019. Particulars 12-17 relate to the Registrant's work at MedsOnline 247 between January and February 2020. Particulars 18- 21 relate to the Registrant's work at MedExpress/Pharmica between 1 March 2022 and 31 May 2022.

66. Particulars 1, 12 and 18 are similar in the conduct alleged. At each of the pharmacies it is alleged on behalf of the Council that the Registrant issued or approved prescriptions for high-risk medicines or medicines requiring on-going monitoring. High risk medicines are defined in the Guidance as '*High-risk medicines are, for example, those liable to abuse, overuse or misuse, or when there is a risk of addiction and ongoing monitoring is important."*. The list of medication considered to be higher risk and/or liable to abuse misuse and overuse was provided by NR, Senior Clinical Pharmacy Advisor and Specialist Inspector for the GPhC. This statement related specifically to the Registrant's prescribing practice at UK Meds.

67. NR in her statement explained that the list contains controlled schedule 3, 4 and 5 drugs which included opioids, benzodiazepines, z- drugs and anticonvulsants.

68. In paragraph 12 of her statement NR states:
"Controlled drugs require a higher level of regulation and can be especially addictive. I considered these to be of higher risk and liable to abuse misuse and overuse. Due to their addictive properties, there is an increased risk of overuse which can lead to overdoses. These can be fatal with opioids which include but are not limited to codeine, co-codamol and dihydrocodeine and benzodiazepines which include but are not limited to diazepam and flurazepam. Overdose with these medicines can lead to respiratory depression and coma".

69. In paragraph 14 of her statement NR explains that the middle column of the list included medicines which were not classified as high-risk (not controlled drugs) but which she considered to be higher risk due to:

'a. medicine's potential to cause serious side effects (for example the side effect profile of carbamazepine as stated in the BNF lists several serious side effects)

b. risk of abuse, misuse, or overuse with the medicines (for example modafinil and weightloss products may be misused or overused)

c. risk of toxicity (for example the BNF monograph for amitriptyline states that overdose 'is associated with a relatively high rate of fatality 'and the SPC entry for propranolol states 'propranolol is known to cause severe toxicity when used in overdose'.

70. NR explained that the right-hand column of her list related to *"…medications* [which] *had a potential to a pose a risk to a person/patient in certain situations and circumstances."*.

71. In her analysis of the prescribing data provided by UK Meds, LT, Case Officer, identified that during the time the Registrant worked for UK Meds she prescribed or approved the prescription of 35,824 prescriptions.

72. In relation to particular 12, VH, pharmacist inspector for the GPhC, undertook an inspection of MedsOnline 247 Ltd on 26 February 2020. Ms VH sets out in her statement that the pharmacy commenced trading on 20 January 2020. She explains that the pharmacy's prescribing service was run by a single PIP, the Registrant. She stated:

"The pharmacy had supplied 199 private prescriptions since its opening and all but two of the prescriptions were for opioid-based medicines, used for the management of pain."

73. VH provided a record of private prescriptions issued by the pharmacy since it began trading. The record, when cross referenced with the list produced by NR, are nearly all examples of high risk/habit forming drugs found in the left-hand column of the list with just one example (amitriptyline) of a high risk non-controlled drug, which would be found in the middle column.

74. Particular 18, relates to the Registrant's issuance of approximately 16,140 prescriptions over three months, whilst working for MedExpress/Pharmacia (1 March 2022 to 31 May 2022). This is supported by a file note produced by LT, which states:

"During these three months, the registrant reviewed 17,752 orders. Of these, 584 were for general sales list items and 1,029 were for pharmacy only drugs, therefore she issued 16,140 prescriptions for prescription only medicines. The medications prescribed included prescribed included weight loss medicines, erectile dysfunction medicines, inhalers for asthma and migraine treatments."

75. It was contended by the Council that these prescription medications, though not high risk-controlled drugs, required on-going monitoring.

76. Particulars 2, 13 and 19 are similar in the conduct alleged. At each of the pharmacies it was alleged that the Registrant:

- failed to obtain adequate information in relation to the patients' health in advance of prescribing;
- relied principally on the information received in an online questionnaire;
- failed to access and/or attempt to access patients' General Practitioner ("GP") medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;
- failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;
- failed to adequately consider the possibility of medication dependence and misuse;
- failed to refer patients back to their GP for appropriate assessment and/or review and/or monitoring;
- failed to put adequate safety-netting in place.

77. These concerns, the GPhC submitted, are basic requirements of a pharmacist prescriber. The

role does not differ whether it is in person or remote, although the risk profile certainly increases with remote prescribing.

78. The Council conceded that in relation to particular 12, it was not alleged that the Registrant relied principally upon the information found within the online questionnaire as it was documented by the disclosure from MedsOnline 247 that the Registrant telephoned each of the patients.

79. There were various standards, guidance and competencies in force at the time the Registrant was undertaking her role as a PIP within these three online pharmacies.

80. The GMC guidance titled *"Good Practice in Prescribing and Managing Medicines and Devices (2013)"* outlines the requirements that a prescriber should satisfy themselves of in their role when considering prescribing an item.

[14] You should prescribe medicines only if you have adequate knowledge of the patient's health and you are satisfied that they serve the patient's needs.

[21] Together with the patient, you should make an assessment of their condition before deciding to prescribe a medicine. You must have or take an adequate history including:

- *a any previous adverse reactions to medicines*
- *b recent use of other medicines, including non-prescription and herbal medicines, illegal drugs and medicines purchased online, and*
- *c other medical conditions.*

[22] You should encourage your patients to be open with you about their use of alternative remedies,

illegal substances and medicines obtained online, as well as whether in the past they have taken prescribed medicines as directed.

[23] You should identify the likely cause of the patient's condition and which treatments are likely to be of overall benefit to them.

81. In a section titled *"Remote Prescribing via telephone, video-link or online"* the guidance states:

[60] Before you prescribe for a patient via telephone, video-link or online, you must satisfy yourself that you can make an adequate assessment, establish a dialogue and obtain the patient's consent in accordance with the guidance at paragraphs 20–29.

82. There were various standards, guidance and competencies in force at the time the Registrant was undertaking her role as a PIP within these three online pharmacies.

83. The GMC guidance titled *"Good Practice in Prescribing and Managing Medicines and Devices (2013)"* outlines the requirements that a prescriber should satisfy themselves of in their role when considering prescribing an item.

[14] You should prescribe medicines only if you have adequate knowledge of the patient's health and you are satisfied that they serve the patient's needs.

[24] Together with the patient, you should make an assessment of their condition before deciding to prescribe a medicine. You must have or take an adequate history including:

- *a any previous adverse reactions to medicines*
- *b recent use of other medicines, including non-prescription and herbal medicines, illegal*

drugs and medicines purchased online, and

- *c other medical conditions.*

[25] You should encourage your patients to be open with you about their use of alternative remedies,
illegal substances and medicines obtained online, as well as whether in the past they have taken prescribed medicines as directed.

[26] You should identify the likely cause of the patient's condition and which treatments are likely to be of overall benefit to them.

84. In a section titled *"Remote Prescribing via telephone, video-link or online"* the guidance states:

[61] Before you prescribe for a patient via telephone, video-link or online, you must satisfy yourself that you can make an adequate assessment, establish a dialogue and obtain the patient's consent in accordance with the guidance at paragraphs 20–29. You may prescribe only when you have adequate knowledge of the patient's health, and are satisfied that the medicines serve the patient's needs. You must consider:

- *a the limitations of the medium through which you are communicating with the patient*
- *b the need for physical examination or other assessments*
- *c whether you have access to the patient's medical records.*

[64] If the patient has not been referred to you by their general practitioner, you do not have access to their medical records, and you have not previously provided them with face-to-face care, you must also:

- *a give your name and, if you are prescribing online, your GMC number*

- *b explain how the remote consultation will work and what to do if they have any concerns or questions*
- *c follow the advice in paragraphs 30–34 on Sharing information with colleagues*

85. In addition to the relevant applicable standards set out above, the Council submitted that the evidence obtained from the three pharmacies demonstrated that the Registrant did not undertake her role with any clinical curiosity about the prescriptions she was approving. This is supported by the volume and speed with which the Registrant was approving prescriptions as well as the evidence provided by the Registrant in an interim order hearing of the Fitness to Practise Committee held in January 2023, in which she stated:

"*So I would read through the questionnaire. So read through the answers that were given, looking at the patient name, the date of birth, why they were ordering the medication, read through all the questions to make sure that the reasons given for ordering the medication was correct. Then I would look at the previous orders and any notes that were on the patient's record. And then the next process would be to either prescribe, reject or refer.*"

86. The Council submitted that nowhere here did the Registrant contend that she would contact a patient to undertake specific assessments or the patient's GP to obtain further information about the patient's medical history.

87. In relation to the charges against the Registrant in her role at UK Meds, LT in her statement set out that in relation to those prescriptions issued by the Registrant on 17,768 occasions, the patient was not asked if they consented to their GP being contacted and on 10,374 occasions, the patient did not consent to their GP being contacted. Neither of these responses it appears made a difference to the prescribing of the Registrant and these prescriptions made up 78.5% of all of the prescriptions issued by the Registrant while at UK Meds.

88. The Council submitted that whilst the Registrant, in her responses above, stated that she would review the reasons why the patient was requesting the medication, and the previous orders on the patient PMR, the examples of patients with multiple repeat orders without review, without contact, without any reference to contact to their GP or any other healthcare professional involved in their care indicated that these basic principles on prescribing were not considered.

89. This was illustrated by LT who identified in her statement in relation to Patient 260528 that 2.5 hours before the Registrant approved a prescription for amitriptyline another prescriber had authorised a prescription for dihydrocodeine.

Particular 3

90. Particular 3 relates specifically to the Registrants work for UK Meds. The Council's case is that regardless of the Registrant contractor status, her role was to ensure that as a prescriber her professional judgement was not compromised and that she was able to perform her role safely and uphold her obligations as a registered pharmacist. By prescribing in the circumstances outlined in the various improvement notices set out to UK Meds, the Registrant was permitting unsafe practices.

91. The Council stated that the Registrant had used what limited information she had been given in the questionnaires and rather than challenge the unsafe practices apparent in the UK Meds prescribing model she had:

- chosen not to contact the patients nor any other healthcare professional to confirm the information provided,
- made many supplies without using her clinical judgement,
- She prescribed in a transactional manner with the evidence showing many hundreds of

instances where supplies had been approved in less than a minute, even with some supplies 20 seconds apart.

92. In disclosure received from UK Meds on 5 March 2019, they stated that results of the electronic ID check were made available to the prescriber, who having had access to the results, approved the patient's order. They stated that the UK Meds' system does not require a service user to 'pass' all of the identification verification checks but makes the results available to the prescriber who will assess the results and decide whether to issue the prescription based on such results together with the information provided to the clinical questionnaire by the patient. The obligation was therefore firmly on the Registrant to ensure that the information she was assessing was accurate.

93. In her evidence at the previous hearing in January 2023, the Registrant stated:

"So with the online pharmacy, you don't actually get to speak with the patient. They've filled out a form online and they've ticked a box to say that all the information that they've supplied is accurate and truthful and that's all you have to go by, whereas in a community setting, you're speaking to the patient, you're confirming their address, their date of birth, you're asking them all the questions, the WWHAM questions, making sure that the medication is relevant for them. So it's more of a face to face contact and it's safer in a way."

94. WWHAM is the acronym for the following questions:

- W: Who is the medicine for?
- W: What are the symptoms?
- H: How long have you had the symptoms? ...
- A: What action has been taken? ...
- M: Are you taking any other medication?

95. The Council submitted that this demonstrated that the Registrant was confirming that she prescribed medications based purely on the answers provided by patients in their questionnaires and appeared to recognise that this is less safe than prescribing in a face-to face setting.

96. The registered pharmacy inspection report, dated 3 September 2019, details that:

"*Questionnaires had a generic section that was specific to the medicine that was being supplied. The customer was able to change their answers. If a person gave an answer which meant it was inappropriate for them to have the medicine, the following box appeared 'Based on the answer you've given us, it would be best for you to consult your GP or specialist. You are unable to continue'. The person could then change their answer, which then allowed for the supply of the medicine and they were able to continue with the purchase. The alteration was not auditable and did not flag to the prescriber or pharmacy"*

97. Within the bundle there was evidence of patients who had orders refused and then made repeat attempts to gain prescriptions (which had been successful). This is particularly demonstrated by Patient 5 and Patient 7.

98. Furthermore, Dr C opined: *"The consultation, however, remains a self-populated questionnaire, where in my opinion, it is easy for a patient to identify which answers could indicate any concerns if answered a certain way"*

Particular 4

99. Data about the Registrant's prescribing was summarised in the statement of LT, and provided to the Committee in excel spreadsheets. 78% of the prescriptions issued by the Registrant were issued in less than one minute. The data demonstrated that the Registrant was issuing

prescriptions on a daily basis and that she was doing so in small blocks of time rather than constantly over the course of a day. Within these timeframes, the Registrant was issuing prescriptions extremely quickly for example on one day, the Registrant approved her first prescription at 7:09 hours and her last at 19:52 hours but did not approve any prescriptions between 10:06 and 19:28. Between 19:29 and 19:52, the Registrant approved 38 prescriptions. This would be an average of one prescription every 36 seconds.

100. The Council submitted that it was therefore impossible that the Registrant would have completed the steps outlined at 4.1 to 4.5 of particular 4, namely:

- read, consider and assimilate the completed questionnaire;
- consider if it was clinically necessary to check with the patients' GP and/or contact the GP;
- consider if it was clinically necessary to contact the patient and/or conduct a face- to-face consultation with the patient;
- consider if it was necessary to check the clinical background of the patient and/or check the clinical background;
- consider the steps the Registrant ought to take to prescribe in accordance with UK prescribing guidance.

Particular 5

101. Schedule A of the Allegation is a compilation of all prescriptions issued by the Registrant in under one minute. Within LT's statement examples are provided of these instances taken from the spreadsheets. 78% of the prescriptions issued by the Registrant were issued in less than one minute. It is inconceivable in the submission of the Council that the Registrant would have been able to properly read through the patient completed questionnaire in this time.

Particular 6

102. Schedule B of the Allegation set out seven patients who had ordered repeat prescriptions from UK Meds and, on the dates set out within the Schedule, the Registrant had issued those prescriptions. In each example there was evidence of previous orders for high-risk medicines which, according to the disclosure provided by UK Meds and the submissions of the Registrant in a hearing, she had access to.

103. LT's statement sets out the relevant prescribing data in relation to each of the patients contained within Schedule B.

104. By way of example, the data for Patient 39427 demonstrated that overall, this patient obtained 56 supplies of prescription only medicine from UK Meds. The Registrant prescribed eight of these prescriptions for opioid based medicine or z-drugs (high-risk medications).

Specific patient incidents

105. In relation to particulars relating to individual patient incidents, many of the concerns are similar, in that the Registrant failed to undertake basic checks such as

- age verification
- checking the previous order history of the Patients
- failing to obtain adequate information from the patient in relation to their medical history for example by contacting them and seeking additional information
- relying principally on the information received in the online questionnaires
- failing to access or attempting to access the patient's medical records or any information from their health providers which may have better informed the Registrant as to the relevant medical picture of the patient
- failing to request a face-to-face consultation in order to provide a proper assessment to the patient, for example this could have been carried out by video call
- failed to consider the possibility of medication dependence or misuse

- Failing to refer the patient back to their usual GP for review, assessment or monitoring
- Failing to put in pace adequate safety netting

106. Not all of these aspects will be relevant to all of the allegations which deal with individual patient incidents. However, as set out by reference to the guidance, framework and competencies of various bodies above, these aspects of patient care are necessary to the assessment of patients and prescribing of medications, particularly high-risk medications and should form part of any assessment undertaken by a PIP. The Council submitted that the Registrant had failed to undertake these obvious requirements and therefore has not placed patient care and safety at the forefront of her practice which had sadly, as illustrated by these examples, led to patient harm.

107. The Registrant asserted in her responses that she had access to the PMR which showed:

"previous medication prescribed by other pharmacist prescribers… I was able to view notes made by prescribers if they were documented, for example if an order was rejected. I was informed by email…on 6th March 2019, that Dr Ambrose would be calling patients and making notes of conversations on the system and that she would upload relevant documents or letters from the GPs and specialists".

108. UK Meds in their disclosure to the GPhC explained that

- *12.1 "created at" means the exact time the consultation was submitted by the patient, I.e., the exact time the consultation was created in the UK Meds system.*
- *12.2 "review date" means the exact time/date the consultation was reviewed by the prescriber.*
- *12.3 "scan time" means the exact time the prescription was dispensed by the pharmacist.*

109. UK Meds explained: "*All prescribers have always been able to see previous requests, refusal reasons, dates and medicines requested, including communications. This has been demonstrated to the GPhC's inspectors during every visit to UK Meds Direct Limited's offices.*"

Particular 7 - Patient 3

110. Patient 3 was a patient with significant opioid dependence issues. Their medical records were produced by the Council. There was a prescription issued by the Registrant for 100 tablets of Dihydrocodeine 30mg on 21 May 2019 based on the answers provided to the questionnaire. The order number on the questionnaire (000811474) corresponds to that on the prescription.

111. As set out by the statement of LT, between issuing this prescription and the previous prescription there were 16 seconds. Between this prescription and the next there was 17 seconds.

112. The patient gave permission for the information to be shared with their GP and for their GP to be contacted. The disclosure shared by UK Meds showed that the GP was not contacted until 7 November 2019 in what appears to be correspondence in relation to a different prescription. It is also fair to point out that the Registrant did refuse a supply to this patient on a later date (08.08.2019). The reason recorded was "*you stated you also currently take co-codamol can't be taken with dihydrocodeine. please clarify if you intend to tak [sic]both?"* In relation to the issuance of this prescription there were previous orders made through UK Meds which, according to the disclosure from UK Meds, the Registrant would have been able to review. This was the sixth time this medicine had been ordered from UK Meds and the fourth time in four months. This specific questionnaire has an amber flagged response in the questionnaire which should have alerted the Registrant to the need for a more in-depth analysis before issuance.

113. There is nothing in the record supplied to demonstrate that the Registrant did anything other

than swiftly approve the medicine based on the online questionnaire. There is no evidence that the Registrant contacted the GP of the patient, followed up that lack of consent with a phone call to the patient or request for a face-to-face consultation. There is a total lack of any clinical assessment or even vague professional curiosity on the part of the registrant in respect of the issuance of this high-risk medication. Once issued, there is no follow up with the patient such as advice or safety netting regarding what steps should be taken next.

Particular 8 – Patient 4

114. Patient 4 was a patient who died as a result of 'mixed drug toxicity with alcohol' on 24 May 2019. After an inquest was held into his death, the Coroner issued a Regulation 28: Report to Prevent Future Deaths which was sent to the National Medical Director for NHS England. Under section 5, Coroners Concerns, it stated:

> *During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances, it is my statutory duty to report to you.*
>
> *The MATTERS OF CONCERN are as follows. –*
>
> *The drugs found in Patient 4's system are known to have toxic effects when taken in excessive amounts in conjunction with other medication.*
>
> *Permitting the patient to "self-certify" without any checks can allow abuse of the system by those most vulnerable who have addiction problems.*
>
> *Permitting the patient the option of not having a GP informed removes an otherwise effective safeguard.*

115. Immediately prior to his death on 20 May 2019 the Patient had obtained 100 Dihydrocodeine

30mg tablets from UK Meds. He had in fact obtained drugs from them on eight prior occasions. On this final occasion, despite having used the service previously, he obtained a "New Customer discount". This final issuance was made by the Registrant. The prescription and relevant questionnaire showed that UK Meds had permission to contact the Patient's GP. According to the disclosure from UK Meds, no contact with a GP or any others involved in Patient 4's care is recorded on his PMR. UK Meds also disclosed that were also no clinical reviews undertaken in relation to the supplies made to this patient. UK Meds stated that there were no clinical review notes or comments in relation to supplies made to this patient. The previous orders made by the patient were provided to the Committee.

Particular 9 – Patient 5

116. On 10 January 2019, the GPhC received a concern from the Medicines and Healthcare products Regulatory Agency (the 'MHRA') regarding the inappropriate supply of Ibuprofen by UK Meds Ltd to Patient 5, a 16 year-old girl, who then used the medication in a suicide attempt. This had initially been reported by the patient's father to the MHRA on 24 December 2018**.**

117. The patient's father provided a statement outlining his daughter's mental health struggles since 2016, and her previous suicide attempts. He disclosed her medical records including a letter from a specialist to her GP on 7 November 2018 stating that the patient has 'chronic suicidal ideations and looks out for opportunities to harm herself'.

118. Patient 5's father describes how he and his wife took measures to prevent their daughter from harming herself. He describes how just before Christmas in 2018, a package came for their daughter. He was unaware it was medication. He thought it was a Christmas present.

119. On 22 December 2019 at approximately 6pm, his daughter took 84 tablets of Ibuprofen 600mg. After a couple of hours his daughter started to stagger around and said she did not feel well. She told her parents what she had done. Patient 5's father reported finding the

empty medicine box and the invoice for the medicine from UK Meds.

120. In response to questions from her father, Patient 5 explained that after having searched for medicines she could take as an overdose she went to the UK Meds website and purchased the Ibuprofen. He asked her if she was asked how old she was and she said 'yes, all I had to do was tick a box to say I was over 18' or words to that effect. Patient 5 said she did not speak to anyone in the pharmacy. She just needed to enter her name, address what medicine she needed. She said she used her own bank card to purchase the medicine.

121. Ibuprofen 600mg is a prescription only medicine as detailed in the correspondence from the MHRA to the patient's father, and in an email from UK Meds to the patient's father on 12 March 2019.

122. On the date of the prescription, as set out in LT's statement, the Registrant *"Between, 2029 and 2032 hours, approximately 3 minutes… approved 9 prescriptions, including the prescription for Ibuprofen for Patient 5….There were 29 seconds from the last prescription she approved to the time she approved the prescription for Ibuprofen for Patient 5."*

123. The Registrant provided two written responses to the events in this particular. Within those responses the Registrant states she followed the following process:

> "*I checked the patient's name, gender, and date of birth to ascertain if the patient was above 18 years old. I was informed that ID checks were carried out by UKMeds to ensure that a patient's identity was verified and authentic. Therefore, I had no reason to assume that the patient was underage.*
>
> *I went through the assessment questionnaire filled in by the patient to ensure that there were no contra-indications or cautions which would raise a cause for referral. With regards*

to the rejection of the request of a prescription the on the 16/12/2018 as mentioned in the allegation, I could not see a reference to any clinical concerns causing the rejection in the patient's notes and there was no evidence documented in the patient's record explaining the clinical basis for which the prescription was rejected. I was also not made aware of any concerns regarding the patient by the pharmacy staff and the Responsible Pharmacist, who also had access to the patient medication record when dispensing and clinically checking the prescription.

I looked at the patient's PMR to see if there were any detailed clinical notes recorded by previous prescribers or the Clinical Lead which had relevant information regarding the patient."

124. In response to questions from the GPHC, the Registrant went into more detail stating that prior to prescribing orders she had sight of failed prescriptions and notes to explain why an order was rejected. She stated that she could not see any document highlighting a reason for the refusal and she therefore made the decision to prescribe based on the information within the questionnaire.

125. As set out above, the Registrant approved this prescription 29 seconds after the previous one. The Council submit that the Registrant could not have performed the tasks she has outlined in her response within 29 seconds.

Particular 10 – patient 10

126. On 5 July 2019, a concern was raised by a community pharmacist, that a patient was able to select opioid painkillers from a website, fill in a short questionnaire and then be sent a large supply of medication which they are addicted to. The pharmacist stated that the company did not inform the patient's regular GP of the supplies. He stated that the patient was now under the treatment of an addiction centre.

127. he patient's PMR, provided by UK Meds, shows that between 28 September 2016 and 25 April 2019, the patient obtained 18 supplies of Dihydrocodeine. The Registrant approved the prescriptions for the fourteenth and eighteenth supplies on the dates alleged respectively.

128. As set out in LT's statement, on 10 January 2019, the Registrant approved 144 prescriptions between 06:40 and 22:34 hours. She was not approving prescriptions continuously throughout the day. The data shows that between 16:27 and 16:32 hours, approximately 5 minutes, the Registrant approved 7 prescriptions, including the prescription for Dihydrocodeine for patient 10. There was 15 seconds between this prescription being approved and the previous prescription.

129. On 25 April 2019, between 03:45 and 04:02 hours, the Registrant approved 40 prescriptions including the prescription for Patient 10. There was 34 seconds between this prescription and the prescription issued immediately prior.

130. If the Registrant had reviewed the previous questionnaires from this patient, she would have seen that the patient was writing almost exactly the same information for each prescription. The Registrant would have also seen from the questionnaire completed on 10 January 2019, that the patient was still referring to her 'newly diagnosed' endometriosis after six months. The questionnaires on both occasions should have prompted the Registrant to obtain further information and seek assistance to work with other professionals listed in the Patient's care. On both occasions that the Registrant issued these prescriptions she did so noting on the prescription "short term use only".

Particular 11 – Patient 16

131. On 1 July 2020, the Council received a concern about the supply of amitriptyline medication to Patient 16. As set out in the witness statement of LT, the Registrant issued a prescription to

Patient 16 on 10 December 2018. The patient's medical record confirms that the patient had a diagnosis of unstable personality disorder. UK Meds confirmed that there was no record of any clinical review notes or comments made in relation to this patient.

132. LT's statement outlines that in the prescribing period where the Registrant prescribed the amitriptyline for Patient 16, she approved 31 prescriptions in 12 minutes. The prescription prior to the prescription for Patient 16 was issued just 16 seconds before. There had been three prior prescriptions issued to Patient 16 by UK Meds which the Registrant would have been able to see from her access to the PMR.

Particular 14 - Patient A

133. The prescription for Patient A was issued while the Registrant provided PIP services for MedsOnline 247 in January 2020. The patient questionnaire gave authority for the Registrant to contact the patient's GP and notify them of the order made. At MedsOnline 247, the Registrant undertook telephone consultations with those individuals seeking prescriptions. Following the telephone consultation, the Registrant issued 100 x 30mg dihydrocodeine.

134. A letter of complaint had been received by MedsOnline 247 in respect of this prescription being issued. It stated:

> *"I am quite alarmed at the way massive amounts of opiates are easily prescribed online without any access to the patient clinical notes. I would like to know what mechanisms are in place to ensure safe prescribing to your clients?...Most of this group of patients are mentally vulnerable and we are quite concerned with the ease with which they can access online opiates in massive amounts".*

135. A copy of the private prescription was included in the documentation before the Committee,

with a section sending a copy of the prescription to the relevant GP practice.

136. VH' statement explained that the superintendent of MedsOnline 247 set out how the service worked. They stated that:

> *"People were able to select the medication they wanted, and they completed an online medical questionnaire which was reviewed by the prescriber. The prescriber then completed a telephone consultation with the patient, prior to approving any supply. The prescriber then notified the pharmacy of the medication that had been approved".*

137. The Council submitted that plainly there was no attempt to contact the GP surgery in advance of issuing the prescription in order to appropriately assess their health condition in advance of prescribing. Additionally, despite her recent experiences at UK Meds, the Registrant failed to consider the possibility that the medication may be being requested to facilitate dependence or misuse and the Registrant in issuing the prescription did not provide the Patient with any safety netting information.

Particular 15 – Patient B

138. In relation to Patient B, this prescription is for co-codamol 30mg/500mg tablets issued on 7 February 2020.

139. The Registrant prescribed the co-codamol for Patient B despite her own note of her consultation in which she recorded that the GP had refused to prescribe the same medication to the patient.

Particular 21 – Patient D

140. Concerns in respect of the issuance of a prescription to Patient D were raised to the GPhC by a clinical pharmacist, Ms C, who provided a witness statement.

141. On 6 April 2022, the GP practice where Ms C is employed received a letter from Pharmica (Med Express) outlining that two Ventolin (salbutamol) inhalers had been prescribed for Patient D. Ms C reviewed Patient D's medical record and saw that they had never been diagnosed with asthma or prescribed Ventolin before. If the Registrant had made any attempt to contact the GP surgery in advance of issuing this prescription, she would have been able to prevent the issuance of an unnecessary prescription only medicine.

Particulars 16 and 17

142. Particulars 16 and 17 relate to the Registrant's actions in respect of providing evidence to the Council regarding Patient C, in her role as a PIP at MedsOnline 247. Patient C obtained a prescription for codeine on 26 February 2020.

143. Following VH' visit to inspect the pharmacy on 26 February 2020, the Registrant emailed Ms VH a document purporting to be a contemporaneous record of the consultations for Patient C, which the Registrant said had taken place on 25 February 2020.

144. The record of the consultation provided by the Registrant by email to Meds Online 247 states: "*Please authorise codeine 3mgx100 per 6 Weeks. Patient has tried tramadol but it does not work. Phone consultation complete".*

145. However, the document the Registrant provided to the GPhC set out a much more detailed consultation:

"Patient has informed me that she had an MRI scan done at the hospital and was diagnosed with injury to the Lumbar region. She has been in pain ever since and was prescribed tramadol but these made her feel sick and were far too strong. Patient has tried paracetamol but is too weak and would like to order co-codamol 30/500mg as this is the only medication which works and she can still function about her daily activities. Patient takes this 1 tablet every 6 hours only when required. Patient is not taking tramadol. I have advised her to see her GP for a review of her pain meds so that they are aware of what works best for her. She has agreed to do so. The reason for ordering was that she can not seem to get an appt with her GP soon enough and is currently in pain".

146. In this instance the Council alleged that the Registrant had produced a document which did not accurately reflect the patient notes on the system at the time. It is alleged that this conduct was dishonest. The Council states that this behaviour is demonstrative of the Registrant actively attempting to deceive her regulator.

Particular 22

147. The Council submitted that the evidence provided by all three pharmacies as to the numbers of prescriptions being issued by the Registrant, at significant pace as outlined in the witness statement and case notes of LT, demonstrates that the Registrant was operating in a wholly transactional manner which was unsafe.

148. In relation to UK Meds as demonstrated by LT's statement and the evidence set out in Schedule A, the Registrant was prescribing at such a rate that 79.3% of the prescriptions she issued were issued in under 1 minute.

149. In relation to the Registrant's role at MedsOnline 247, VH, pharmacist inspector for the GPhC

undertook an inspection of MedsOnline 247 on 26 February 2020. VH sets out in her witness statement that the pharmacy commenced trading on 20 January 2020. The pharmacy's prescribing service was run by a single PIP, the Registrant. At paragraph 9 of her statement, she states:

"The pharmacy had supplied 199 private prescriptions since its opening and all but two of the prescriptions were for opioid-based medicines, used for the management of pain."

150. VH provided a record of private prescriptions issued by the pharmacy since it began trading. The medications prescribed were nearly all examples of high risk/habit forming drugs, with just one example (amitriptyline) of a high risk non- controlled drug.

151. In relation to the Registrant's role at Medexpress/Pharmica it was stated in disclosure from Medexpress on 19 July 2023 that the hours worked by the Registrant were 7.25 hours per week for 13 weeks of the year. During the 3-month time period the Registrant issued 16,140 prescriptions. This would equate to a prescription being issued by the Registrant every 21 seconds.

152. The data supports that the Registrant was acting in a dangerously transactional manner which did not permit proper opportunity for the review and reflection upon the various questionnaires she was provided and thus led to unsafe prescribing practices.

153. The Council submitted that in relation to the examples provided by the Registrant of where she has rejected prescriptions as can be seen at the Registrant's response to concerns at MedsOnline 247 – these rejections only evidence occasions instigated by the patients themselves rather than the use of any professional skills on the part of the Registrant and do not support that the Registrant was prescribing in anything other than a transactional manner.

Particular 23

154. This particular relates to the Registrant's role at Medexpress/Pharmica and UK Meds. The evidence states that the Registrant would receive payment for each prescription approved. The Registrant therefore received an income directly in relation to this employment solely in relation to prescriptions issued.

Oral Evidence

155. Dr C provided two expert reports, dated 20 June 2022 and 15 May 2023, in relation to the remote prescribing model at UK Meds only: she did not examine the Registrant's alleged conduct. Much of Dr C's evidence in her reports has been summarised above and is not repeated here.

156. In oral evidence, Dr C explained in broad terms that the difficulty with remote prescribing, though she was not opposed to it in principle, was that patients treat it rather like shopping at Amazon – they decide what drug they want, they do not expect a diagnosis. Red flags when remote prescribing include cases where the type of drug requested is open to misuse; patients may or may not have had it before; there may be risk of duplicate prescribing; the fact that a patient could obtain the medication free in Scotland or for a small prescription price in England, yet is prepared to spend significant sums of obtaining it from a private online prescriber.

157. Dr C explained that the difference with community prescribing is that patients usually use the same pharmacy and there will be face to face contact. In her opinion, remote prescribing, particularly of medication open to abuse or addiction, is only safe if the prescriber communicates directly with the patient for example phone, video-call, or email – a questionnaire alone is unsafe.

158. In answer to panel questions, Dr C stated that in circumstances where a patient had requested controlled drugs or for example prescription only drugs which can be misused, but had refused consent to contact being made with their GP or GP surgery, then a prescriber's professional responsibility required them to signpost the patient elsewhere. They should decline to prescribe the medication being requested.

The Registrant's Evidence:

159. The Registrant had provided written responses including reflections in her documentary evidence, along with certificates of training and CPD and testimonials.

160. She also gave oral evidence to the Committee, both in relation to the facts and to stage two, grounds and impairment. In addition to questions from Ms Hewitt, the Registrant was cross examined by Ms Manning-Rees, and answered panel questions. The main points of the Registrant's evidence in relation to the facts are summarised below:

- She came to Britain alone aged 15 and stayed with family contacts, qualifying as a pharmacist at UCL in 2006 and thereafter as a Pharmacist Independent Prescriber (PIP) at the University of Brighton in 2015.
- Her first experience of online prescribing was from 2015 at MedExpress, where she also worked in person in the travel clinic, and where there was an adjacent online pharmacy which specialised in lifestyle medication for example for erectile dysfunction and weight loss. She became an RP and later the SI for this pharmacy. She worked at MedExpress until August 2022, at first full time, and later, part time only in the online pharmacy.
- In 2018 she was contacted by a recruiter and invited to join UK Meds as an online prescriber, which she did. That was when she went part time as a PIP at MedExpress to work fully remotely, and relinquished the roles of RP and SI.
- She stated that she had never really looked at the GMC guidelines because they were for doctors, nor did she know in detail the guidelines of the Royal Pharmaceutical Society (RPS) – as a pharmacist she concentrated mainly on the GPhC guidelines and worked in

accordance with the policies and SOPs at her places of work, which were written by doctors and pharmacists. The GPhC guidelines on providing pharmacy services at a distance weren't issued until November 2019.

- At the time she worked for UK Meds there was no need to contact GPs: the GPhC knew that was the model at UK Meds; there didn't seem to be any concern; both MedExpress, which underwent three GPhC inspections during the time she worked in person, 2014-18, and UK Meds, passed all inspections with only minor adjustments.
- In relation to UK Meds, she assumed that as UK Meds was registered with the GPhC, it must surely follow appropriate guidelines. She never imagined UK Meds would be unethical.
- At all three pharmacies, she did not carry out ID checks – she said she had no reason to believe they were not being properly conducted. The GPhC knew how they were conducted (eg variously via Sagepay, Experian and Onfido) and accepted the model.
- A few months into her role at UK Meds, the Registrant felt there wasn't enough support from the clinical lead and SI, she felt uneasy about the prescribing model and emailed the clinical lead (a doctor) to raise her concerns. She was told the SOPs were in the process of being updated. She continued to work despite her concerns for far too long. She didn't undertake any clinical checks other than reviewing the patient questionnaires. She would accept or reject the requests for medication and she referred any queries to the Clinical lead who was supposed to do the follow up checks. In relation to repeat requests, the Clinical lead was supposed to review the requests after every third repeat and remove the patient from the system if further prescriptions would be inappropriate; therefore she assumed all patient questionnaires requiring repeats were ok.
- The prescribing models at MedExpress and UK Meds were similar: she would log on in the morning between 7 and 8 am and go through the lists – the difference was that at MedExpress there was an automated traffic light system whereby requests which would be flagged red were automatically removed from the lists which reached her; those which needed referral were flagged amber; and those which passed the prescribing criteria were green. At MedExpress she would then authorise prescriptions in batches; at UK Meds, where there was also an automated colour-flagging system, but no automatic removal of red flagged requests, she would reject those which obviously needed to be rejected, refer

others, and then go through the remaining questionnaires, accepting in batches the ones she considered appropriate.

- At MedsOnline 247, a start-up, (as was MedExpress) she was the only PIP, and she would phone every patient to assess suitability for prescribing. GPs were only contacted after prescribing.
- When asked by Ms Hewitt why in her judgement she came to prescribe in all three of the online pharmacies as alleged and accepted by her, she said a number of factors came into play: it was a model widely in practice at the time; at first she was only dealing with lifestyle medications, not controlled drugs (though she fully and consistently accepted in evidence that such medications, as prescription drugs, required clinical monitoring for safety which she had not undertaken); she relied on doctors and other pharmacists who had drafted the questionnaires and SOPs; and she accepted that it was due to her own poor judgement. She told the Committee that she had raised concerns by email both at UK Meds and at Meds Online 247 (one such email was in the documentation) – and had been told that things would improve, so she waited. She should not have done so.
- The Registrant maintained throughout that at UK Meds she did read and consider each questionnaire, though she accepted that she did not do so at MedExpress/Pharmica. However, she did not conduct her own initial checks including contacting the GP before prescribing/face-to-face consultations/obtaining patients' medical notes. She stated that she had no means to contact GPs, and she was not provided with a work phone. She stated that at MedsOnline 247 she spoke on the phone to all patients but realised this was not sufficient, especially given the type of medication being sold, so she left there after only five weeks.
- When shown the data and spreadsheets which had been provided by LT, the GPhC's case officer, which appeared to show in very many instances that at UK Meds, there were only a few seconds between a patient's request being received and the Registrant approving a prescription, the Registrant said she could not comment on the data but it did not reflect what she had done. She had not been dishonest. She had considered every request for medication (after rejecting the obvious ones which did not pass the prescribing criteria) and only after that she had approved them in batches. She did not consult with the patient, GP

or others, and based her approval solely on the information provided by the patient within the questionnaire. Her rationale for this that she was following company policy.

- The Registrant accepted throughout that, at the time of the alleged events, she had failed to observe professional standards and she accepted that her actions had in part led to serious consequences for patients, including, in the case of Patient 4, contributing to his death. In that case, the Registrant said she was shocked and mortified to realise that the consequences of part of what she was doing had led to the patient's death, it was "just horrific", she could not express how sorry she was that this had happened. She described this as a "slip-up".
- The Registrant accepted that her explanations in relation to the context of her online prescribing practice did not absolve her of her professional responsibility as a prescriber: it was not "ok" simply to say she had been following company policies, though she maintained that she had done so throughout. She said, in relation particularly to UK Meds, that when in that situation, "you're battling within yourself, well I'm in this job, I need to do my best, work hard, follow the guidelines and policies set out for me". She had raised concerns, it was causing her so much stress, she was not feeing safe, feeing on edge, she should have left UK Meds a lot sooner.
- The Registrant answered questions in relation to her prescriptions for the specific patients set out at particulars 9, 10, 11, 14, 15 and 21, which she did not recall specifically, given the lapse of time since the alleged events. She had in any case accepted the particulars in full.
- In relation to her prescribing at MedsOnline 247, the Registrant explained that this was a start-up and the systems weren't fully developed – she had no access to the online system to input her own notes or issue prescriptions online. The owner (who was not a registered pharmacist) would email her the list of patient questionnaires and she would phone every patient for a consultation. In relation to those she approved, she would then "instruct" the owner by email to tell the pharmacist assisting him to dispense medications. She would create prescriptions in pdf format which she would email to them. She would write her own clinical notes in a notepad or on her laptop with the intention of uploading them on the pharmacy system at a later date when it was up and running. The Registrant's evidence when she first referred to the issue of the system not being fully developed was that it never was until after she left the pharmacy, however later in questions from the panel she said it

was possible to upload notes onto the system in the last week or so of her employment at the pharmacy.

- The Registrant said she had never been shown Document 5, the GPhC Inspection Report into Pharmica dated 6 May 2021.
- In relation to particulars 16 and 17, the Registrant explained that the email to the owner was brief because it was just an instruction, whereas her notes which she provided later to the GPhC inspector were more detailed. She denied dishonesty. She did however accept that the note did not show her rationale for prescribing codeine.
- The Registrant denied that she was motivated by financial gain over and above the patient safety: she told the Committee that at MedExpress/Pharmica she was on a salary; and at UK Meds she would get paid the same amount (£2.50) whether she accepted or rejected a prescription request. At MedsOnline 247 she was paid only for approved prescriptions (£5 per prescription), but she denied that this affected her decision-making.

Submissions in relation to the disputed facts

161. In her general submissions on the facts, Ms Manning-Rees submitted that whilst much of the evidence in relation to this case is based on data, extrapolated by case officers and the expert opinion of Dr C, this evidence was cogent and persuasive evidence of the facts alleged in each particular as set out above. The Committee should rely first and foremost on the documentary evidence, though the oral evidence of the Registrant should also be taken into account, as set out in the case of *Dutta v GMC* [2020] EWHC 1974 which reiterated the principles from the cases of *Gestamin SGPS SA v Credit Suisse (UK) LTD* [2013] EWHC 3650*:*

"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, motivation and working practices 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 provided any reliable guide to the truth".

162. The Committee should bear in mind that the Registrant had not challenged the contents of the statements provided by the witnesses by requiring their attendance at a hearing or requiring them to give evidence, nor of the spreadsheets showing her prescribing patterns at UK Meds. In relation to particular 5, the data clearly showed that the Registrant's account was a complete fabrication. Particular 23 was inextricably linked to that in that the only reason for prescribing as she did was because she didn't care and was just making money. Ms Manning-Rees submitted that the Registrant favoured her wallet over patient safety. The same motivation explained her prescribing practices at MedsOnline 247 and MedExpress/Pharmica where all she did was turn up say four hours a week, click a button to prescribe drugs already approved by a computer system, simply collecting a fee without using her PIP qualification to do it – with devastating results.

163. Ms Hewitt submitted that the Registrant had been caught up along with many other prescribers, especially at UK Meds, in working for an organisation which itself did not have patient safety at heart. Mistakes were made, these businesses were allowed by the GPhC to continue. The Registrant had taken too much comfort in believing the online sifting systems were robust but also in the GPhC inspections which had allowed the businesses to continue. She was an honest pharmacist and did not lack integrity; she had not been influenced by financial gain and had walked away from the pharmacies when she became concerned and improvements were not being made. She had accepted most of the particulars, and had fully engaged and had gone a long way to recognising her mistakes and remediating them.

Decision on Facts

164. In reaching its decisions on facts, the Committee considered all of the documentation listed at the start of this determination, and the oral evidence of Dr C and of the Registrant, and the submissions made by Ms Manning-Rees on behalf of the Council, and by Ms Hewitt on behalf of the Registrant.

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

Particular 5:

"In relation to 1 above, on all or some of the dates and orders outlined in Schedule A, you approved a prescription in circumstances where the time taken (less than a minute) would not have allowed you to properly read through the patient completed questionnaire".

166. The Committee appreciated that, as was explained in evidence by Dr C, it can sometimes be appropriate for a prescriber to consider requests for prescriptions in groups or batches and then issue the prescriptions in batches thereafter. In such circumstances, it may appear from the electronic record of the prescription approvals that they were issued in very quick succession.

167. However, in relation to this particular, the Committee took into account the spreadsheets which had been created by LT, the GPhC case officer, with information supplied by UK Meds. It showed, unequivocally, in the Committee's opinion, that not only had the Registrant on 275 occasions, issued prescriptions in less than one minute after a patient had submitted a request, but moreover, many times during those very short periods, the Registrant was in fact "approving" multiple requests for prescriptions from other patients. She would have been left

with very few seconds – frequently as few as two or three – to assess a patient questionnaire. It was not possible, in the Committee's view, for the Registrant even to have been skim-reading through the questionnaires, let alone for her to have had sufficient time to properly assess the clinical appropriateness of the patients' requests, especially given the high- risk nature of the medications being requested.

168. The Committee took into account that the Registrant, when questioned, had simply said that she could not comment on the data set out in the spreadsheet; she maintained that it did not reflect what she had done. She had told the Committee that at UK Meds she would reject the "red" alert requests in a group, then go through the rest of the questionnaires one by one, deciding whether to refer or accept them; and then she would later press the button to accept the requests for medication in batches.

169. Having carefully weighed the documentary evidence before it against the Registrant's accounts, both written and oral, the Committee was satisfied that the evidence on behalf of the Council in relation to this particular was irrefutable: the Registrant could not have had time to properly read through the patient completed questionnaires.

170. The Committee therefore found particular 5 proved.

Particular 16:

"In relation to 12 above, on or around 26 February 2020 you emailed to GPhC, a document purporting to be contemporaneous records of consultations including for Patient C who was prescribed codeine on 25 February 2020".

171. The Committee found this particular proved on the basis of what the Registrant had said about the document: it was a compilation of patient notes which the Registrant had created in response to a request from the GPhC inspector. The notes purported to be contemporaneous

records of consultations including for Patient C who was prescribed codeine on 25 February 2020".

Particular 17

"Your conduct at 16 above was dishonest in that:

17.1 you knew it was not a contemporaneous record because the contemporaneous record you emailed to the pharmacy owner on 25 February 2020 stated only "Please authorise codeine 30mg x 100 per 6 weeks. Patient has tried tramadol but it does not work. Phone consultation complete Naureen Walji."

17.2 you knew that the note you sent included details which would suggest you had recorded a fuller clinical rationale for prescribing a high-risk medicine than the one you relied on to issue the prescription".

172. The Committee carefully considered all of the evidence before it in relation to particular 17. The note which the Registrant had sent to the GPhC inspector recorded as follows:

"Patient has informed me that she had an MRI scan done at the hospital and was diagnosed with injury to the Lumbar region. She has been in pain ever since and was prescribed tramadol but these made her feel sick and were far too strong. Patient has tried paracetamol but is too weak and would like to order co-codamol 30/500mg as this is the only medication which works and she can still function about her daily activities. Patient takes this 1 tablet every 6 hours only when required. Patient is not taking tramadol. I have advised her to see her GP for a review of her pain meds so that they are aware of what works best for her. She has agreed to do so. The reason for ordering was that she can not seem to get an appt with her GP soon enough and is currently in pain".

173. The Registrant, appearing to have very clear recall of the consultation from 2020, had told the Committee that codeine was prescribed because the patient, having stated that paracetamol was too weak and had reserves of paracetamol at home, and so she told the patient she would issue a prescription for codeine instead. The Committee observed that the note did not record any discussion with the patient about substituting her preferred medication for codeine or an explanation for doing so. The Registrant had told the Committee that she spoke to the pharmacist dispenser at the pharmacy and told him her reasons for prescribing codeine but forgot to write them in the contemporaneous note.

174. The Committee was concerned that the note did not therefore reflect the Registrant's account in her oral evidence of the consultation with the patient, nor the actual medication prescribed. The Committee was also somewhat surprised that the Registrant in her evidence was able to recall in detail the discussion with the patient which took place in 2020, and also a conversation with the pharmacist dispenser and yet nevertheless, she accepted, she had not accurately recorded the consultation in the note which she said was a contemporaneous record.

175. The Committee considered the questionnaire completed by Patient C. The patient said their condition was: *"Lumbar back pain L4 & L5. Diagnosed a few years ago. Pain in my lower back which comes and goes depending on what I've been doing".*

176. Where the questionnaire asked the patient to *"Tell us Where Your Pain is Located, What Makes It Worse And Better, And What Other Treatments You Have Previously Used For This Condition",* the patient in the questionnaire, had written:

"Lower back. It hurts if I am either sat down for long periods of time or I'm stood up for too long. Ive tried Tramadol. This doesn't help me and it makes me feel sick. Cocodamol is the only thing that relieves the pain".

177. The Committee observed that the note alleged to be contemporaneous closely followed the patient's comments in the questionnaire, albeit with detail added for example in relation to an MRI scan and reference to paracetamol. It did not, however, reflect the prescribing decision as set out in the Registrant's email to the pharmacy owner, which was to prescribe codeine.

178. The Committee carefully considered all of the evidence before it in relation to this particular.

179. It took into account the principles set out in the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67, which has subsequently been followed in professional regulatory proceedings:

> *"When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of [their] belief is a matter of evidence (often in practice determinative) going to whether [they] held the belief, but it is not an additional requirement that [their] belief must be reasonable; the question is whether it is genuinely held. When once [their] actual state of mind as to knowledge or belief as to facts is established, the question whether [their] 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 [they have] done is, by those standards, dishonest."*

180. The Committee did not think it plausible, or credible, that if the note had been written contemporaneously, then the Registrant would not have recorded her decision to prescribe codeine instead of what the patient requested, namely co-codamol. Nor was it credible that, having recorded the note so inaccurately at the time, the Registrant would be able to recall so precisely, when giving evidence to this Committee, that she had decided to prescribe codeine and, on her account, had told the patient that she would do so, and had also told the pharmacist dispenser to do so, but omitted to record this in her contemporaneous note.

181. Taking all of the evidence before it into account, the Committee was of the view that when the Registrant provided the note of the consultation, she knew that it was not in fact a contemporaneous note of a consultation with Patient C. She knew that it was consistent with what the patient had written in the questionnaire, where a request for co-codamol was made. But she may not have noticed that it was entirely inconsistent with the actual prescription she

approved, namely for codeine.

182. Following the case of ***Ivey***, the Committee considered that, applying the (objective) standards of ordinary decent people, what the Registrant did was dishonest.

183. In coming to this conclusion, the Committee took into account that the document containing the note seemed to include notes in random date order and were not, the Registrant stated, a full record of all the notes made that month. The Committee could think of no credible reason for the inaccuracies in the note, set out within an incomplete and apparently random list of other notes, but that the Registrant must have dishonestly fabricated it when asked for evidence of note taking by the GPhC inspector on 26 February 2020.

184. The Committee therefore found particular 17 proved.

Particular 23

"Your approach to prescribing in all or some of allegations 1 to 11 and 18 to 22 lacked integrity in that you placed financial gain and/or an eagerness to please your employer over and above patient safety".

185. The Committee carefully considered all of the evidence before it.

186. The Registrant been open in admitting that her prescribing practice at the time of the allegations was at fault in that she did not properly or sufficiently scrutinise the patient questionnaires at all three pharmacies where she was prescribing remotely. She had been open and clear about how she was paid at each of the pharmacies: at UK Meds she was paid £2.50 for each approval and rejection; at MedsOnline 247 she was paid £5 per approval only (red flagged requests were rejected by the computer system before they reached her); and at MedExpress/Pharmica she was paid a flat fee of £800 per month. She had told the Committee that, in relation to UK Meds, she could have just rejected every request and still been paid; moreover, she had left all three roles when she realised her concerns were not

being dealt with – at UK Meds she had felt increasingly "unsafe", unsupported by the Clinical lead and SI – and currently, she was working on a low wage as a beauty therapist because she enjoyed the work, whereas she could have got a job as a manager.

187. The Registrant denied emphatically that she had been motivated by financial gain. It was unclear whether the Registrant accepted that she had been motivated by a desire to please her employers, as she had earlier appeared to accept this, and had taken a leadership course, she said, to improve her assertiveness, but later before the Committee she denied this had motivated her. She denied that her approach to prescribing had lacked integrity, as alleged.

188. The Committee took into account evidence from the Registrant in a previous hearing, which was as follows:

> *"…UK Meds, the model, was quite – it was a high-pressure environment where they were quite mean in a way in terms of meeting certain targets and when I did reach out to them, trying to communicate with them, there wasn't much communication back. I felt that pressures from them in the sense of to reach the targets that they needed"*

> "*…I was informed that there were pharmacists that were refusing all the prescriptions, every single one, because they didn't want to prescribe, and they were still getting paid for the ones that they weren't prescribing and so they had issues with those pharmacists and I was informed not to do that. You know, don't refuse medication just because you don't want to work but you want to get paid for it. So then, in my mind, I don't want to be the type of pharmacist that is refusing everything where there is need but then I think I should have been more vigilant with what I was prescribing and been more careful*."

189. The Committee carefully considered the evidence before it about how she prescribed during the periods in question. At UK Meds she issued 35,824 prescriptions in about ten months and at MedExpress/Pharmica, 16,140 in the approximately three months set out in the particulars. Evidence from UK Meds showed that she would sometimes be up in the middle of the night issuing prescriptions, and she often worked late into the evenings. She was working for a number of different pharmacies at the same time. As has been found above, she would issue multiple prescriptions over such short periods of time that she could not have been properly assessing whether the patient questionnaires appropriately met the prescribing criteria, as she had been trained to do.

190. The Committee was satisfied that the evidence before it demonstrated not only that the Registrant's approach to prescribing was transactional, as she had in fact admitted in relation to particular 22, but also that she was motivated by financial gain over and above patient safety. Moreover, the Committee was of the view that she was, as alleged, eager to please her employers. She had told this Committee, and had also told a previous Committee as set out above, that the employer at UK Meds had told her not to simply reject all requests as some of her colleagues had been doing: the Committee considered that this employer directive gave the Registrant an incentive to ensure that she maintained a healthy record of prescribing, in order to retain her role – at an employer from whom she earned in excess of £89,000 over less than one year.

191. Taking all of the evidence before it into account, the Committee found that the Registrant placed financial gain and also an eagerness to please her employer over and above patient safety; and it also found that this approach to prescribing lacked integrity.

192. The Committee therefore found particular 23 proved in its entirety.

STAGE TWO: IMPAIRMENT

193. Having made its determination in relation to the facts, the Committee went on to consider whether those facts amount to misconduct and, if so, whether the Registrant's fitness to practise is currently impaired by reason of her misconduct.

194. Article 54(1) of the Pharmacy Order 2010 provides:

"The Fitness to Practise Committee must determine whether or not the fitness to practise of the person in respect of whom the allegation is made (referred to in this article as "the person concerned") is impaired".

195. The Council's recently revised Good decision making: Fitness to practise Hearings and Outcomes Guidance (March 2024), Paragraph 2.12 states:

> *"2.12 A pharmacy professional is 'fit to practise' when they have the skills, knowledge, character, behaviour and health needed to work as a pharmacist or pharmacy technician safely and effectively. In practical terms, this means maintaining appropriate standards of competence, demonstrating good character, and also keeping to the principles of good practice set out in our various standards, guidance and advice."*

196. "Misconduct" has been termed a "gateway" which may lead to a finding of current impairment. Article 51(1) of the Pharmacy Order 2010 provides that:

> *"A person's fitness to practise is to be regarded as "impaired" for the purposes of this Order only by reason of:*
> *(a) misconduct*
> *[various other grounds…]".*

Evidence

197. The Registrant provided both written and oral evidence in relation to grounds and impairment. She had admitted the majority of the facts alleged by the Council and had accepted in her written responses, that she had failed to observe her professional standards.

198. In response to questions from Ms Hewitt, the Registrant accepted that if she had been a family member of some of the patients she had issued prescriptions for and who had come to harm, then she would have been "furious, hurt and upset". She accepted that by her conduct she had "tarnished" her own reputation and that of her profession- she had years of good practice before these events, she'd worked hard to get to where she was, she enjoyed looking after patients and serving the community; it had come to this. It was not in her nature to have acted as she did in these pharmacies.

199. The Registrant told the Committee that she understood that as gatekeeper of medications which can be abused or are addictive, her responsibility was first and foremost patient safety. She said that pharmacists are often patients' first port of call and patients should be able to trust them. she stated patients would lose faith and trust in the profession and that it was not fair on other pharmacists because of her actions.

200. The Registrant had in her oral evidence provided explanations for her conduct at the time of the events in question: it was, she said, a mixture of believing that since she was working for pharmacies regulated by the GPhC and she was aware of a number of GPhC inspections during her time at the pharmacies, which passed in principle, she assumed that the processes at the pharmacies were appropriate. She always followed the processes and procedures in place at the various pharmacies, though when she had concerns she raised them. She said she should have left UK Meds sooner than she did but she kept being told that processes would be updated or improved and she waited too long. She left MedsOnline 247 within a few weeks of joining them, when she had realised their methods of prescribing were unsafe.

201. In relation to current impairment, the Registrant said that in hindsight she did not think prescribing online is a safe model, particularly the volumes - in such large quantities; she did not think that prescribing online fits the general prescribing criteria; in hindsight she should never have worked for the online pharmacies, but at the time the guidelines for PIPs were not published; she accepted that she had become complacent.

202. Since then, the Registrant said, she has remediated her failings by shadowing a pharmacist who works in a GP setting and had been a second pharmacist, supervised, in a community setting, both roles unpaid; and she had undertaken appropriate CPD training, for which she provided documentary evidence; she also provided testimonials including from those she had shadowed since the events. She had not been in a position to apologise personally to patients she had harmed but she would be willing to do so.

203. She now understood that it was her personal responsibility as a professional to check from start to finish including ID and clinical appropriateness before prescribing; as prescriber, she was similar to a doctor, no different; she had learned a lot from her past.

204. The Registrant accepted that she had relied entirely on what the patients wrote without any professional curiosity and that she did not meet the pharmacy standards.

205. As to the risk of repetition, the Registrant said that in future she would:

- follow GPhC guidelines;
- work with other healthcare professionals for example, in a community or GP setting;
- would not work ever again in an online setting – “it’s just not safe”;
- she would like to retake a prescribing course to refresh her own knowledge and skills;
- she would continue to work on her clinical progression, for example by taking a CPPE course on clinical pathways, which she had to stop given these proceedings;
- she would follow NICE guidelines.

- She had reflected on her strengths and weaknesses, her moral compass, her integrity as a pharmacist.

206. In relation to risks and actual patient harm, the Registrant said what she had done was "really really bad" – she could not believe she hadn't seen that sooner; the extent of harm caused to so many patients, the risks that online pharmacy can cause to the public, to patients and to their families. She accepted if she were a member of the public hearing a pharmacist had behaved as she did, she would think terribly of them and judge them.

207. Her hopes for the future were to work in a community setting and not as a prescriber until she had regained confidence and, following further training, felt competent to do so.

Submissions

208. Ms Manning-Rees, on behalf of the Council, referred the Committee to her skeleton argument and the relevant law.

209. She submitted that the conduct which the Committee had found proved was in breach of Standards 1, 2, 5, 6 and 8 of the Standards for pharmacy professionals (2017). It fell far below the standards of practice to be expected of registered pharmacists and would be considered deplorable by fellow professionals; it therefore met the threshold for a finding of misconduct.

210. Turning to current impairment, Ms Manning-Rees drew the Committee's attention in particular to the case of *Fopma v GMC*, [2018] EWHC 714 (Admin), in which the Judge, Baker J, dealing with the question of impairment and specifically what is meant by "the reputation of the profession", stated: "*A failure to find impairment in any given case, whilst warnings as to future conduct can still be issued, is tantamount to an indication on behalf of the profession that conduct of the kind need not have regulatory consequences. If that, depending on the nature of the conduct in question, would itself be an unacceptable conclusion, then that can in any given case be a sufficient basis in itself to justify or indeed compel a conclusion of impairment*".

211. Ms Manning-Rees submitted that all four limbs of Rule 5(2) of the Rules were engaged. The Registrant had merely paid lip-service to reflection, remediation and insight, and had sought to blame others, and the systems and organisations in place at the online pharmacies where she was working. She submitted that the Registrant, in her oral evidence, had ably described the processes she should have followed but she did not do so; she continues to fail to understand the depth of her failures, and therefore her conduct is highly likely to be repeated.

212. In relation to the wider public interest, Ms Manning-Rees submitted that the public would be horrified if a finding of impairment were not made in the circumstances of this case.

213. Ms Hewitt, on behalf of the Registrant, reminded the Committee that for a finding of misconduct, a Registrant's conduct has to have been serious and fallen far below the expected standards. She reminded the Committee that there is no automatic presumption of impairment following a finding of misconduct.

214. Ms Hewitt submitted that the Registrant has taken steps to remedy her conduct and now recognises that the online setting is a dangerous one: the Committee should weigh into the mix, when exercising its professional judgement, all of the contributing factors which led to the Registrant's conduct, including the wider state of online pharmacy, the fact that the GPhC had allowed the processes where she worked to continue; and that the relevant GPhC guidance only came into effect in 2019.

215. In relation to the wider public interest, Ms Hewitt submitted that carrying out this hearing which is in public, itself sends a powerful message which can be brought to the attention of other professionals and the public; the Committee should ask itself what a reasonable member of the public, in all the circumstances of this case, would expect in order to uphold and maintain the wider public interest.

The Committee's Decision on Misconduct

216. The Committee took into account the submissions on behalf of both parties and the relevant law and guidance, including reference to the Council's "Good Decision- making: fitness to practise hearings and outcomes guidance" (March 2024). It bore in mind that it was a matter for its own professional judgement whether the conduct ithad found proved was so serious as to amount to misconduct.

217. It took into account the Council's overarching objective which is the protection of the public, by:

• protecting, promoting and maintaining the health, safety and wellbeing of the public

• promoting and maintaining public confidence in the profession

• promoting and maintaining proper professional standards and conduct for members of the profession.

218. The Committee accepted the submissions of Ms Manning-Rees in relation to the Council's "Standards for pharmacy professiona**ls** (May 2017). It determined that there had been breaches of the following Standards:

a. **Standard 1: pharmacy professionals must provide person-centred care:** the Committee has found that the Registrant's approach to prescribing was transactional and that it lacked integrity in that she placed financial gain and/or an eagerness to please her employer over and above patient safety.

b. **Standard 2: pharmacy professionals must work in partnership with others:** the Registrant was approving patients' requests for potentially dangerous medication without checking or consulting with others, for example patients' GPs, to ensure it was appropriate to prescribe them;

c. **Standard 5: pharmacy professionals must use their professional judgement:** the Registrant breached this standard by approving large volumes of patient requests for medications without considering whether the medication was clinically appropriate;

d. **Standard 6: pharmacy professional must behave in a professional manner**: one requirement of working in accordance with this standard is to be trustworthy and act with honesty and integrity: the Committee has found that the Registrant was dishonest in relation to a purported contemporaneous note of a consultation, and that her approach to prescribing lacked integrity. The Registrant was therefore in breach of this standard.

e. **Standard 8: Pharmacy professionals must speak up when they have concerns or when things go wrong:** the Registrant told the Committee that she repeatedly expressed her concerns at UK Meds, and the Committee has seen an email she sent to the owner at MedsOnline 247 following a complaint about her prescribing to a patient; however she did not adequately challenge the poor systems in place at the pharmacies, and continued to work, especially at UK Meds, for far too long despite concerns she says she had.

219. 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).

220. The Committee carefully considered its findings on the facts. It had found that the Registrant, both at UK Meds and at MedExpress/Pharmica, was prescribing very large volumes of Controlled Drugs, the vast majority of which were opioids and z-drugs, which are well- known to be prone to abuse and misuse, and are known to be addictive. She did so without properly reading through the patient questionnaires – in the case of MedExpress/Pharmica, she admitted in oral evidence that there was one button, that is, the “bulk prescribe” button, on her computer which she would press to approve multiple prescriptions at once. She made no efforts at those two pharmacies to contact patients’ GPs or even to check their ID for herself.

221. The Committee considered in particular the data analysis produced about the Registrant's prescribing practice at UK Meds. LT, case officer for the GPhC, explained in her witness statement that the data analysis showed for example that of 35,824 prescriptions approved by the Registrant on 23 July 2018 and between 12 November 2018 and 29 September 2019, on 17,768 occasions, patients were not asked if they consented for their GP to be contacted and on 10,347 occasions, patients did not consent to their GP being contacted. This equates to 78.5% of all prescriptions approved by the Registrant. Moreover, the data demonstrated that she approved 28,405 prescriptions within one minute of the previous prescription she had approved, which was 79.3% of the total number of prescriptions she issued during her time at UK Meds.

222. On one day, 24 November 2018, between 0802 and 0814 hours, approximately 12 minutes, the Registrant approved 34 prescriptions, 30% of the total number of prescriptions she approved on that day.

223. The Registrant had told the Committee that this evidence did not reflect what she had in fact been doing, however the Committee when making its factual findings, had preferred the documentary evidence on this matter.

224. The Registrant's evidence in relation to her practice at MedsOnline 247 was that she conducted patient consultations on the phone – but GPs were only notified after a prescription had been issued; and again she did not check their ID for herself.

225. The Committee could not but be alarmed at such conduct. As Ms Manning-Rees had submitted, and as should have been entirely obvious to the Registrant, the professional standards expected of her applied no matter what setting she was working in: online settings are no different from face-to-face settings. The Registrant had ably described to the Committee in oral evidence the steps she should have taken when prescribing – from checking a patient's ID, to following her professional standards to ensure that a prescription was clinically justified – however she failed to observe those standards at all three pharmacies as set out in the Particulars of Allegation.

226. The data included many examples of the Registrant prescribing dihydrocodeine to patients who had been supplied the same medication multiple times by UK Meds – if the Registrant had taken the necessary care to check even the patient medication records available from her own employer, let alone to contact the patients' GPs, she would have been alert to the danger of harm to those patients.

227. The Committee is of the view that the Registrant would have known that such prescribing could endanger the health, safety and wellbeing of her patients (or of other members of the pubic who might obtain possession of the medication) – and at least one patient died after taking the prescription medication she had authorised. Indeed, she told the Committee that she was concerned about what she was doing. She nevertheless continued to prescribe in this way at UK Meds for a considerable period of time, and, having left UK Meds due, she said, to her concerns, she then repeated her conduct at two further workplaces.

228. The Committee accepted the submissions of Ms Manning-Rees in relation to the Registrant's practice whilst at the three online pharmacies: by persistently failing to undertake proper reviews of patients seeking high risk medications, she enabled patients who were suffering from issues with addiction and seeking to harm themselves to circumvent the highly regulated system of obtaining medication. She completely failed to recognise her personal professional responsibility, as what is often termed the gatekeeper of those medications, for each prescription she approved, in exactly the same way as she would have been in a community-based setting.

229. In the Committee's view the Registrant's breaches of her professional standards and her neglect of her professional responsibilities were seriously reprehensible. Her conduct fell below acceptable and expected standards for pharmacy professionals, and would be considered deplorable by her fellow practitioners.

230. For the reasons above, the Committee is satisfied that the ground of misconduct is found proved.

The Committee's Decision on Impairment

231. Having found misconduct proved, the Committee went on to consider whether the Registrant's fitness to practise is currently impaired. Rule 5 of the Rules sets out the criteria which the Committee must consider when deciding, in the case of any Registrant, whether or not the requirements as to fitness to practise are met.

232. Rule 5(2) of the Rules states:

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

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

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

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

(d) Shows that the integrity of the registrant can no longer be relied upon."

233. Guidance on this issue, (echoed the Council's revised Guidance (2024) at Paragraph 2.15), was set out by Mr Justice Silber in *Cohen v General Medical Council [2008]* EWHC 581 (Admin) at paragraph 65:

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

234. Applying the considerations set out in the case of *Cohen*, the Committee took into account that this was a pharmacist who had been qualified for many years, and had risen to the role of RP and SI when working in person as a pharmacist. There had been no previous concerns raised with her regulator about her practice. However, when she became qualified as an

independent prescriber, and changed her role to working remotely in an online setting, her approach to prescribing was, the Committee has found, transactional in nature; and she practised with a view to financial gain and pleasing her employers over and above patient safety. She failed to observe the most basic of professional standards over a prolonged period of time and in three different workplaces. In addition, the Committee has found, in relation to particular 17, that her conduct was dishonest.

235. The Committee was of the view that the Registrant's conduct which led to the charge would be very difficult to remediate.

236. As for whether the Registrant has, in fact, remediated her conduct, the Committee carefully considered the evidence provided by the Registrant in relation to current impairment. She had provided two detailed written responses in which she accepted the majority of the allegations, and expressed her remorse for, and insight into, her conduct.

237. She had provided certificates demonstrating attendance at CPD courses on subjects including addiction, misuse and dependency; deprescribing; deprescribing opioids in people with chronic pain, alcohol and substance dependence, prescription writing and safeguarding children, all of which, the Committee considered, were relevant to the misconduct it had found proved.

238. The Committee also took into account the testimonials provide by the Registrant. HK, Senior Pharmacist Advanced Clinical practitioner, whom the Registrant had shadowed on occasions during July-November 2023, commended her gentle and kind character, however, in relation to the Registrant's standard of practice, Ms HK wrote: *"It was evident [the Registrant's] situational awareness regarding effective, safe prescribing was limited".* DG, who supervised the Registrant in a community pharmacy between May and November 2023, who wrote in his workplace supervisions report: *"[the Registrant] performed well and I could not see any issues that may have caused alarm bells…I truly believe that if [the registrant] had enhanced*

leadership skills, she may have navigated away from the situation that resulted in" these fitness to practice concerns.

239. The Committee also took into account a testimonial from Miss L, a pharmacist who had worked with the Registrant in a community pharmacy from 2019-2022 and considered her to be honest and trustworthy, and to have worked within protocols, appropriately consulting with patients and rejecting medications on a daily basis.

240. However, taking all of the evidence before it into account, the Committee remained very concerned both at the nature of the Registrant's misconduct, and at the extent of her insight and reflections into her conduct.

241. The Committee was of the view that the Registrant's oral evidence in relation to a number of matters could not be relied on. In particular, she had maintained in the face of documentary evidence to the contrary, that she had properly assessed the patient questionnaires which she approved at UK Meds, whilst elsewhere she accepted that she could not have had time to do so.

242. The Committee accepted the submissions of Ms Manning-Rees to the effect that the matters which the Registrant has put forward in mitigation for her misconduct, serve only to demonstrate a continuing lack of full insight into her own professional responsibilities to her patients and the public. She has continued to place blame on the systems within which and the organisations for whom she worked. She has sought to divert responsibility variously to the lack of adequate leadership, guidance and policies where she worked; the dangers of online pharmacy in principle; the fact that her employers were carrying out ID checks so there was no reason to question them; the fact that the pharmacies were regulated by the GPhC; and the fact that the GPhC guidelines for PIPS were not published until 2019. She told the Committee that the online pharmacy model did not allow for contact with patients,

which was plainly not the case. She also said that she did not think that the Standards for pharmacy professionals (2017) applied in an online setting.

243. No doubt the processes in place at the online pharmacies where she was working were seriously wanting, and it is of note that the directors were not themselves registered to prescribe – however, as the PIP, it was the Registrant who was the gatekeeper of the potentially harmful medications she was prescribing – she would have known full well how to prescribe safely – and in the view of the Committee, she was complicit in the poor operating standards which prevailed at the places she was working. Ultimately, if she felt there were deficiencies in what she knew about the patient and their medical history then it was her professional responsibility as a registered professional to have made further enquiries to satisfy herself that her decision to prescribe was safe and in the best interests of the patient.

244. Given the Committee's view that the Registrant has not fully taken on board her professional responsibility for her failings, it follows that it is therefore not satisfied that she would not repeat them in future.

245. Taking into account all of the above, the Committee does not consider that the Registrant has remedied her conduct and it is not persuaded that her conduct is highly unlikely to be repeated.

246. The Committee next considered Rule 5(2) of the Rules. It accepts the submissions of Ms Manning-Rees in that (a) the Registrant currently presents an actual or potential risk to patients or to the public; (b) she has brought the profession of pharmacy into disrepute; (c) she breached not just one but a number of the fundamental principles of the profession of pharmacy; and, given the Committee's findings in relation to particular 23, and also its assessment of her incomplete insight and reflection into her conduct, the Registrant's conduct (e) shows that her integrity can no longer be relied upon.

247. The Committee therefore is of the view that the Registrant's fitness to practise is currently impaired on the personal component.

248. Turning to the wider public interest, the Committee bore in mind the case of *CHRE v NMC and Grant* [2011] EWHC 927 (Admin) in which it was said:

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

249. Ms Hewitt had submitted that regulatory proceedings in and of themselves can in suitable cases, send a powerful message to fellow professionals and the public, and had reminded the Committee that it should ask itself what a reasonable member of the public would expect ought to be done to uphold and maintain the wider public interest.

250. However, the Committee is of the view that in a case as serious as this, where the Committee has found a current risk of repetition and therefore of harm to the public, members of the public would be shocked if a finding of current impairment were not made in the wider public interest. It is satisfied that the need to uphold professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances of this case.

251. The Committee therefore finds that the Registrant fitness to practise is currently impaired, both on the personal component, and also on the public component, that is, in order to uphold professional standards and public confidence in the profession and in the regulator.

Decision on Outcome

252. Having found impairment, the Committee went on to consider the appropriate outcome.

253. The Committee's powers in relation to sanction are set out in Article 54(2) of the Pharmacy Order 2010.

254. Article 54(2) of the Order provides:

> *"If the Fitness to Practise Committee determines that the person concerned's fitness to practise is impaired, it may–*
>
> a. *give a warning to the person concerned in connection with any matter arising out of or related to the allegation and give a direction that details of the warning must be recorded in the person concerned's entry in the register,*
> b. *give advice to any other person or other body involved in the investigation of the allegation on any issue arising out of or related to the allegation;*
> c. *give a direction that the person concerned be removed from the register;*
> d. *give a direction that the entry in the Register of the person concerned be suspended, for such period not exceeding 12 months as may be specified in the directions; or*
> e. *give a direction that the entry in the Register person of the person concerned be conditional upon that person complying, during such period not exceeding 3 years as may be specified in the direction, with such requirements specified in the direction as the Committee thinks fit to impose for the protection of the public or otherwise in the public interest or in the interest of the person concerned."*
>
> The Committee may also make no order.

255. The Committee was aware that it should consider the available outcomes in ascending order from the least restrictive, taking no action, to the most restrictive, removal from the register, in order to identify the appropriate and proportionate outcome that meets the circumstances of this case. It bore in mind that the purpose of the outcome is not to be punitive, though an outcome may in fact have a punitive effect. The purpose of the outcome is to meet the overarching objectives of regulation, namely the protection of the public, the maintenance of public confidence and to promote and uphold 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 GPhC's guidance, entitled: Good decision making: Fitness to practise hearings and outcomes guidance (March 2024), ("the Good decision making Guidance") which reminds the Committee that it must consider the full range of outcomes.

Submissions

257. Ms Manning-Rees referred the Committee to her skeleton argument and submitted that the Registrant's conduct was fundamentally incompatible with continued registration and so the only reasonable and proportionate order was removal. She set out the Council's submissions in relation to the aggravating and mitigating factors of the Registrant's conduct. She submitted that the Registrant poses an actual risk of harm to patients as had been sadly evidenced actual patient harm. She had provided limited reflection and insight; the risk of the Registrant continuing to practise with a lack of clinical judgement was high. The Registrant has, in the submission of the Council, breached a fundamental tenet of the profession in that she has failed to put patient safety first and has failed in her duty to protect patients.

258. As a gatekeeper of high-risk medications, especially as a prescriber, the Registrant had shown a disregard for her position and exposed many patients to harm by prescribing in an indiscriminate manner; and she had been found by the Committee to have been dishonest.

259. Ms Hewitt, on behalf of the Registrant, reminded the Committee of the relevant law and guidance, emphasising that the Committee must consider the full range of outcomes available to it. She submitted that the Registrant had shown some insight. She proposed mitigating factors in the case which included that the Registrant has demonstrated, since the events, a desire to remain in practice, maintaining her CPD and having shadowed pharmacists, at her own not inconsiderable personal expense, including significant travel between her home in the Midlands and the community pharmacy where she shadowed Mr DG in Brighton. She also reminded the Committee that Mr DG had formed the impression that the Registrant had a good nature, was extremely caring, trying too hard to please everybody, and didn't realise that at times she should say no. It was he who had recommended that she attend a leadership course.

260. Ms Hewitt also submitted, in mitigation, that, whilst not detracting from her own responsibility, the Registrant had taken some comfort whilst working in an online setting, from GPhC inspections which appeared to be positive. There is an inherent danger, Ms Hewitt said, in businesses being run by unlicensed people hoping to make money: in the long term something has got to be done about it. The business first named in the Allegation had, it was believed, now "swanned off to Dubai", well out of reach of the GPhC. Ultimately, it is always the small people, the little people, who get caught up in it. Ms Hewitt submitted that these were her observations in the hope that someone somewhere hears them.

261. In relation to outcome, Ms Hewitt submitted that the Registrant had expressed a wish to return to "grass-roots" as a pharmacist. She said she would not make unrealistic submissions as to outcome and that the starting point from a "stair-up" approach should be conditions. A lengthy period of robust conditions, preventing the Registrant from prescribing, with a review, might be appropriate. This would reflect the public interest in retaining an experienced pharmacist. This Registrant had practised for 17 years with no previous fitness to practise concerns, had demonstrated a commitment to remaining on the register. Failing that, a lengthy suspension period with a review might be appropriate. Ms Hewitt submitted that this is a profession which the Registrant does love, and she could be given a chance to demonstrate to a future reviewing panel that she has remedied her conduct.

The Committee's Decision

262. The Committee had regard to the relevant law and to the Council's *'Good decision-making: Fitness to practise hearings and outcomes guidance* (March 2024)' ("the Good decision-making Guidance"), to inform its decision. It took into account the submissions made by Ms Manning-Rees and Ms Hewitt.

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

264. The Committee identified the following aggravating factors:

- The drugs concerned include prescription only high-risk drugs;
- The volume of prescriptions issued (52,163 in total;)
- The prescribing practice spanned thee different online-pharmacies;
- The conduct was sustained over a period of time;
- Vulnerable patients were not appropriately assessed or managed;
- The transactional nature of the Registrant's practice;
- The dishonest interactions with the regulator;
- The actual harm and potential risk of harm to patients who were prescribed medications by the Registrant;
- Potential financial gain by virtue of the Registrant's transactional prescribing.

265. The Committee identified the following mitigating factors:

- The Registrant is of previous good character and has no previous Fitness to Practise concerns against her;
- The Registrant experienced high working pressure at UK Meds;
- The Registrant worked at MedsOnline 247 for only about five weeks.

266. The Committee next turned to consider the sanctions available to it in ascending order.

267. Take no Action: The Committee first considered where it would be appropriate to take no action, however it was of the view that this outcome would not protect the public nor would it be sufficient to reflect the seriousness of the Registrant's misconduct.

268. Warning: The Committee next considered whether issuing a warning would be appropriate but it decided that a warning would not be appropriate for the same reasons as above, namely that a warning would not protect the public nor sufficiently mark the public interest. The Committee also was of the view that a warning would not be proportionate to the seriousness of the Registrant's failings.

269. Conditions of Practice. The Committee next considered whether to impose conditions of practice. The Good decision-making Guidance states that conditions may be appropriate where there is evidence of poor performance, or significant shortcomings in a professional's practice, but the Committee is satisfied that the professional may respond positively to retraining and supervision; and where there is not a significant risk posed to the public by the imposition of conditions.

270. The Committee bore in mind that Ms Hewitt had submitted that conditions may be an appropriate outcome in this case, and carefully considered conditions as a possible outcome. However, the Committee did not consider that the Registrant's conduct resulted purely from professional shortcomings which could be remediated by a period of work subject to conditions. The Committee had determined that the Registrant's approach to prescribing was transactional and lacked integrity. The Committee had also found that she was dishonest. In summary, the Registrant abdicated her professional responsibility towards her patients' safety.

271. The Committee was of the view that conditions would not be appropriate or relevant in this case. Moreover, given its findings in relation to the Registrant's integrity and honesty, the Committee could not be sure that the Registrant would comply with conditions. In any case,

the Committee considered that an order for conditions would not be sufficient to mark the seriousness of the matter so as to maintain public confidence in the Registrant, the profession and the regulator.

272. Suspension Order. The Committee next considered whether suspension would be a proportionate sanction. The Committee took into account Ms Hewitt's submission to the effect that a lengthy period of suspension together with a review would be an appropriate outcome in this case. It carefully considered the Council's Good decision making guidance which indicates that suspension may be appropriate where:

> *"The Committee considers that a warning or conditions are not sufficient to deal with any risk to patient safety or to protect the public, or would undermine public confidence. When it is necessary to highlight to the profession and 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".*

273. The Committee took into account that the Council's Good decision making guidance states at paragraph 5.7 and 5.8 that in reaching a decision on what outcome to impose, the Committee should give appropriate weight to the wider public interest. The Committee is entitled to give greater weight to the public interest, than to the consequences for the professional. Even if an outcome will have a punitive effect, it may still be appropriate.

274. The Committee accepted that the public would be protected from any risk of harm whilst the Registrant was suspended from the register. It therefore turned to consider whether a suspension would be adequate and proportionate to maintain public confidence in the profession and proper standards of behaviour.

275. The Committee took into account all of the mitigating factors of the case which it had identified. It bore in mind the Registrant's desire to return to the profession which she loves,

and her willingness and intention to return to grass-roots to ensure she could practise safely and effectively going forwards. However, the Committee bore in mind that the Standards for pharmacy professionals (2017) apply to pharmacists no matter what their professional role: this includes non-prescriber roles, RP and SI roles, and those in non-senior roles.

276. After careful consideration of the seriousness and nature of its findings, the Committee concluded that a period of suspension, even of 12 months, which is the longest period which it can impose, would not satisfactorily mark the gravity of its findings. It was satisfied, having given appropriate weight to all of the evidence before it, that members of the public were they to be appraised of all the evidence in this case, would be shocked if the Registrant were to receive a suspension, even of 12 months, with the possibility, even subject to review, of returning to the register thereafter.

277. Removal. Having concluded that a period of suspension would not satisfactorily deal with the issues of public protection and public interest which it has identified, the Committee considered whether removal was in fact more appropriate. The Committee took into account that removal is reserved for the most serious conduct. The Sanctions Guidance states that:

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

278. In relation to its finding of dishonesty in relation to particular 17, the Committee took into account paragraphs 6.8 and 6.9 of the Council's Good decision making guidance:

"6.8 The GPhC believes that dishonesty damages public confidence, and undermines the integrity of pharmacy professionals. However, cases involving dishonesty can be complicated – committees should carefully consider the context and circumstances in which the dishonesty took place. Therefore, although serious, there is not a presumption of removal in

all cases involving dishonesty…6.9…Some acts of dishonesty are so serious that the Committee should consider removal as the only proportionate and appropriate outcome. This includes… falsifying patient records".

279. Whilst fully appreciating that a finding of dishonesty must not lead to automatic removal, the Registrant's dishonesty found proved at particular 17 falls squarely within the above example. The Committee could find no reason to depart from the Council's guidance in this regard.

280. Taking all of the evidence into account, the Committee has come to the view that the Registrant's conduct is indeed fundamentally incompatible with being a registered professional and therefore removal is the only reasonable and proportionate order it can make today.

281. The Committee therefore directs that the entry in the Register of Ms Naureen Amirali Walji whose registration number is 2066151, be removed.

282. The Committee revoke the current Interim Order.

Decision on Interim Measure

283. Ms Manning-Rees for the Council, made an application for an interim measure of suspension to be imposed on the Registrant's registration, pursuant to Article 60 of the Pharmacy Order 2010, pending the coming into force of the Committee's substantive order. She submitted that such an order was necessary to protect the public and was otherwise in the public interest.

284. Ms Hewitt reminded the Committee that whether or not to impose an interim measure was a matter for its professional judgement – it should not be automatic. An interim measure

should only be imposed if the Committee is satisfied that it is necessary for the protection of members of the public or is otherwise in the public interest.

285. The Committee carefully considered the Council's application. It took account of the fact that its decision to order the removal of the Registrant's name from the register will not take effect until 28 days after the Registrant is formally notified of the outcome, or until any appeal is concluded. The Committee also took into account the Council's Good decision making hearings and outcomes guidance of 2024.

286. The Committee has found that the Registrant's misconduct merits an order of removal. It has also found that there is a risk of repetition. It is satisfied that it is therefore necessary for an interim measure of suspension to be in place from today's date, both to protect the public and in the wider public interest.

287. The Committee therefore hereby orders that the entry of the Registrant in the register be suspended forthwith, both on grounds of public protection and in the wider public interest, pending the coming into force of the substantive order.

288. This concludes the determination.