General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

In person at General Pharmaceutical Council,

One Cabot Square, Canary Wharf, London E14 4QJ

23 - 27 September 2024

Registrant name:	Gary Choo
Registration number:	2030022
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Lubna Shuja (Chair) Jignesh Patel (Registrant member) Tanya Kynaston (Lay member)
Committee Secretary:	Zainab Mohamad
Registrant:	Present and represented by Martin Hadley (solicitor of VHS Fletchers)
General Pharmaceutical Council:	Represented by Alecsandra Manning-Rees (Counsel)
Facts proved by admission:	1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14. 10 (based on “some” medicines) 15 (based on “words to that effect”).
Facts not proved:	None
Fitness to practise:	Impaired
Outcome:	Warning

Particulars of Allegation (as amended)

You, a registered pharmacist, the Superintendent Pharmacist ('SI'), and regular Responsible Pharmacist ('RP') of FCL Health Solutions Ltd, Guardian House, Cronehills Linkway, West Bromwich, West Midlands, B70 8GS ('FCL Chemist') between 1 August 2018 and 11 October 2019, failed to provide safe and effective care in that you provided services at a distance through ***www.mymedsuk.com*** and***:***

1. *You failed to ensure that FCL Chemist and/or the prescriber carried out sufficiently robust identity checks to prevent patients making multiple and/or fraudulent prescription requests.*
   [Admitted]

2. *You failed to ensure that FCL Chemist effectively monitored and/or reviewed prescriptions to prevent misuse or abuse.*
   [Admitted]

3. *You oversaw a system of prescribing which enabled prescribing contrary to the GMC Good practice in prescribing and managing medicines and devices guidance, the Royal Pharmaceutical Society ('RPS') and/or the General Pharmaceutical Council ('GPhC') in that the questionnaires and/or the prescriber:*

   3.1 failed to obtain adequate information from patients;
   3.2. failed to establish whether the patient had communication or support needs;
   3.3. failed to determine capacity to provide consent to treatment;
   3.4. failed to obtain or attempt to obtain details of the patient's physical health;
   3.5. failed to obtain or attempt to obtain details of the patient's mental health;
   3.6. 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;
   3.7. failed to request a face to face consultation with patients in order to adequately examine the clinical need for the medication;
   3.8. failed to adequately consider the possibility of medication dependence and/or misuse;
   3.9. failed to query with the patient's the frequency of requests for medication and/or the amounts requested;
   3.10. failed to refer patient's back to their GP for appropriate assessment and/or;
   3.11. failed to put adequate safeguards in place such as sufficient identity checks.
   [Admitted]

4. *You failed to ensure that FCL Chemist operated in a safe and effective manner in that:*

   4.1. FCL Chemist's website was arranged so that a person could choose a Prescription Only Medication and its quantity before there had been an appropriate consultation with a prescriber and;
   4.2. patients were able to change their answers to consultation questions.
   [Admitted]

5. *You failed to ensure that FCL Chemist:*

5.1. managed the risk that people may deliberately provide incorrect information to receive medicines that they wanted, despite them being clinically inappropriate;
5.2. proactively shared relevant information about the prescriptions they issue with other relevant healthcare professionals involved in the care of the patient including their GP;
5.3. contacted the patient's GP in advance of issuing a prescription for high-risk medicines to confirm that the medicine was appropriate for the patient and/or that appropriate monitoring was in place;
5.4. obtained a clear record from the prescriber setting out their justification for prescribing, in circumstances where they decided to issue a prescription when the person did not have a GP or did not consent to share information and /or;
5.5. contacted the patient's GP following issuance of a prescription so that reactive reviews could be undertaken if necessary.
[Admitted]

6. *You failed to ensure that the services FCL Chemist provided at a distance, including the prescribing service, had been adequately risk assessed.*
   [Admitted]

7. *You worked with a prescriber and/or FCL Chemist's owner who you knew was trying to circumvent regulatory oversight by the Care Quality Commission in that the prescriber used a 'desk address' based in Romania to avoid the need for CQC registration.*
   [Admitted]

8. *In relation to 7 above, your conduct lacked integrity.*
   [Admitted]

9. *You oversaw the dispensing of approximately 44,322 prescriptions for high-risk medicines and/or medicines that required ongoing monitoring.*
   [Admitted]

10. *In relation to 9 above, you dispensed all or some of the medicines to patients in approximately the quantities outlined in Schedule A on the basis of an online questionnaire when they are unsuitable to prescribed on that basis.*
    [Admitted on the basis of "...*some of the medicines...*"]

11. *On some or all of the occasions set out in Schedule B you dispensed the medicines to the patients outlined in that schedule in circumstances where you:*

    11.1. knew or should have known that the patient had already made repeated orders for the same medicine from FCL Chemist;
    11.2. failed to adequately consider the possibility of medication dependence and misuse and/or;
    11.3. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring.
    [Admitted]

12. *In relation to 9 above, you oversaw a prescribing model for dispensing high-risk medicines which had not been prescribed in accordance with relevant guidance from the GMC, RPS and GPhC in circumstances where you:*

    12.1. failed to obtain adequate information in relation to the patient's health in advance of dispensing;
    12.2. 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;
    12.3. failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;
    12.4. failed to adequately consider the possibility of medication dependence and misuse and/or;
    12.5. failed to refer patient's back to their GP for appropriate assessment and/or review and/or monitoring.
    [Admitted]

13. *In relation to 9 above, you dispensed two prescriptions of 112 tablets of Codeine Phosphate on 3 May 2019 and 12 July 2019 and one prescription of 14 tablets of Zimovane 7.5mg on 28 May 2019 to Patient D, a patient with history of addiction to opiates, anxiety and depression. In circumstances, where you:*

    13.1. failed to ensure you had all of the necessary information to ensure that the supplies to be made were clinically appropriate and safe for the patient;
    13.2. failed to ensure that the patient's GP or other treating healthcare professionals were consulted before the supply was made and/or;
    13.3. failed to make adequate clinical checks before dispensing and/or referring the patient back to their GP for appropriate assessment.
    [Admitted]

14. *In relation to 9 above, you dispensed 112 tablets of Codeine Phosphate 30mg on 14 May 2019 and 14 tablets of Zopiclone 7.5mg on 15 August 2019 to Patient E, a 7-year-old. In circumstances, where you:*

    14.1. failed to verify their age;
    14.2. failed to ensure you had all of the necessary information to ensure that the supplies to be made were clinically appropriate and safe for the patient;
    14.3. failed to ensure that the patient's GP or other treating healthcare professionals were consulted before the supply was made and/or;
    14.4. failed to make adequate clinical checks before dispensing.
    [Admitted]

15. *During a GPhC Pharmacy inspection in October 2019, you stated:*

15.1. "It was better they get drugs from the pharmacy than the back of an Audi" or words to that effect; and
15.2. You were aware that Modafinil was being ordered by students to help them stay awake during exam revision or words to that effect.
[Admitted on the basis of "...*words to that effect*"]

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

Schedule A

Medicine	No of prescriptions (approx.)
Opioids	24,054
Z-Drugs	15,575
Modafinil	1,285
Amitriptyline	279
Orlistat/Xenical	17
Ventolin	139
Pregabalin	593
Finasteride	18
Gabapentin	149
Sildenafil	100

Schedule B

Date (s)	Medicine/quantity	Patient Customer ID
8 November 2018;	28 tablets of Dihydrocodeine 30mg	4710537d-d576- 4625-9117-2644ab3f7cfc
14 November 2018;	28 tablets of Dihydrocodeine 30mg	
20 November 2018;	28 tablets of Dihydrocodeine 30mg	
27 November 2018;	28 tablets of Dihydrocodeine 30mg	
3 December 2018;	28 tablets of Dihydrocodeine 30mg	
11 December 2018;	28 tablets of Dihydrocodeine 30mg	
17 December 2018;	28 tablets of Dihydrocodeine 30mg	
25 December 2018;	28 tablets of Dihydrocodeine 30mg	
2 January 2019;	56 tablets of Dihydrocodeine 30mg	
17 January 2019;	56 tablets of Dihydrocodeine 30mg	
30 January 2019;	56 tablets of Dihydrocodeine 30mg	
3 March 2019;	100 tablets of Dihydrocodeine 30mg	
30 March 2019;	100 tablets of Dihydrocodeine 30mg	
30 April 2019;	100 tablets of Dihydrocodeine 30mg	
13 August 2019;	28 tablets of Dihydrocodeine 30mg	
20 August 2019;	28 tablets of Dihydrocodeine 30mg	
6 September 2019 and/or;	28 tablets of Dihydrocodeine 30mg	
30 September 2019	28 tablets of Dihydrocodeine 30mg	
5 August 2018;	100 tablets of Dihydrocodeine 30mg	611cabd7-6121-4c86- 964a-b306875ef6f6
6 September 2018;	100 tablets of Dihydrocodeine 30mg	
16 October 2018;	112 tablets of Dihydrocodeine 30mg	
20 November 2018;	112 tablets of Dihydrocodeine 30mg	
17 December 2018;	112 tablets of Dihydrocodeine 30mg	
6 February 2019;	112 tablets of Dihydrocodeine 30mg	
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6 February 2019; 12 February 2019; 12 March 2019; 3 April 2019; 3 May 2019; 7 June 2019; 2 July 2019; 30 July 2019; 16 August 2019 and/or; 24 September 2019	14 tablets of Zolpidem 10mg 112 tablets of Dihydrocodeine 30mg 14 tablets of Zolpidem 10mg 14 tablets of Zolpidem 10mg 100 tablets of Dihydrocodeine 30mg 14 tablets of Zolpidem 10mg 14 tablets of Zolpidem 10mg 14 tablets of Zolpidem 10mg 100 tablets of Dihydrocodeine 30mg 100 tablets of Dihydrocodeine 30mg	
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26 June 2019; 23 July 2019; 19 August 2019 and/or; 24 September 2019	56 tablets of Amitriptyline 25mg 56 tablets of Amitriptyline 25mg 56 tablets of Amitriptyline 25mg 56 tablets of Amitriptyline 25mg	
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Documentation

- GPhC Hearing Bundle (655 pages)
- GPhC Statement of Case and Skeleton Argument dated 5 September 2024
- The Registrant's Bundle (41 pages)
- The Registrant's Skeleton Argument and Statement of Case dated 16 September 2024
- Expert Report from Dr Grace Campbell dated 15 May 2023

Witnesses

The Registrant – gave oral evidence at grounds and impairment stage.

Determination

Introduction

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

2. The matter concerns Gary Choo ('the Registrant') who is registered with the Council as a Pharmacist, registration number 2030022. The Registrant first registered with the Royal Pharmaceutical Society of Great Britain on 30 July 1984 and subsequently transferred to the Council.

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

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

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

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

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

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

6. A Principal Hearing has up to three stages:

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

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

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

Service of Notice of Hearing

7. A letter dated 7 August 2024 from the Council headed 'Notice of Hearing' was sent to the Registrant. This had been sent by email to the Registrant's registered email address on the same date in compliance with Rule 3 of the Rules. No issue with service was taken by either party. The Committee was satisfied that there had been good service of the Notice in accordance with Rules 3 and 16.

Application to amend the Particulars of the Allegation

8. The Committee heard an application from Ms Manning-Rees, on behalf of the Council under Rule 41 to amend Allegation 2 to remove the word *"all"*. She submitted the Council accepted it would be too onerous to expect the Registrant to review all the prescriptions but the Council's case was that he should have reviewed some. Ms Manning-Rees also applied to correct a minor typographical error in Allegation 15.1 and amend the word "*that*" to "*than*".

9. Mr Hadley, on behalf of the Registrant, confirmed there was no objection to the application to amend Allegation 2, indeed it had been suggested by the Registrant and would be admitted if amended. Mr Hadley did not object to the typographical correction in Allegation 15.1. He confirmed that the proposed amendments would cause no prejudice to the Registrant and did not alter his case.

10. The Committee noted the proposed amendments were agreed by both parties. The amendment to Allegation 2 was proposed to remove an overly onerous expectation on the Registrant and reflect the Council's case. The amendment to Allegation 15.1 corrected a typographical error. It was in the interests of justice and of a fair hearing that the Registrant was clear about the facts relied upon by the Council. Accordingly, the Committee granted the application for the amendments as requested.

Application for the hearing to be held in Private

11. The Committee heard an application from Mr Hadley under Rule 39(3) to hold a discrete part of the hearing in private. Mr Hadley stated that there were health issues that the Registrant would refer to. Whilst Mr Hadley accepted it was in the public interest for the hearing to be held in public and the majority of the hearing would be in public, there was a particular personal issue the Registrant wanted the Committee to be aware of as it could potentially impact on the hearing.

12. (REDACTED)

13. Ms Manning-Rees did not object to the application for parts of the hearing to be held in private.

14. (REDACTED) Mr Hadley assured the Committee that he had discussed the matter with the Registrant and the Registrant did not wish to delay this hearing. He wanted to proceed and did not wish to apply for a postponement. He felt he was able to currently fully participate notwithstanding his personal circumstances.

15. The Committee granted the Registrant's application for any health matters to be dealt with in private. It was important that the Registrant's right to a private life was protected (REDACTED). Accordingly, the Committee decided to hold certain parts of the hearing in private where there were references to (REDACTED) health in order to protect the Registrant's privacy.

The Registrant's response to the Particulars of the Allegation

16. The Registrant admitted Allegations 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13 and 14.

17. The Registrant admitted Allegation 10 on the basis that he had dispensed "*some of the medicines to patients …* " not "*all"* of the medications. This admission was accepted by Ms Manning-Rees on behalf of the Council, and she confirmed the case would be presented on that basis.

18. The Registrant admitted Allegation 15 on the basis that it was pleaded as *"...words to that effect"*. The Registrant did not accept that he had used the exact words stated in Allegation 15. Mr

Hadley had set out in his Skeleton Argument what the Registrant believed he had said to the Council's Inspectors which was as follows:

> "15.1 He believed that a pharmacy provides a controlled environment for vulnerable patients and that it is better to get their medicines from a pharmacy rather than the back of an Audi.
>
> 15.2 He was aware that students could use Modafinil to stay awake during exam revision."

19. Ms Manning-Rees confirmed that this admission was also accepted, as little turned on the exact wording. She did not seek to challenge the Registrant's recollection in this regard.

20. Accordingly, the Committee found the admitted factual Allegations 1-15 **proved** under Rule 31(6) of the Rules, with Allegations 10 and 15 admitted on the basis set out above.

21. The Committee went on to consider whether the ground of misconduct was proved on the admitted Allegations, and if so, whether the Registrant's fitness to practise is currently impaired which is a matter for the Committee's judgement.

Background

22. The Registrant was the Superintendent ('SI') and regular Responsible Pharmacist ('RP') at FCL Health Solutions Ltd ('the Pharmacy') from March 2018 to June 2020. The Pharmacy was an entirely online/distance pharmacy. From August 2018, the Pharmacy delivered online services to patients through a website called **www.mymedsuk.com** ('MyMedsUK'). Dr S, a General Practitioner registered with the General Medical Council ('GMC'), was the Pharmacy's Prescriber ('the Pharmacy's GP Prescriber'). No face-to-face consultations took place. Patients could request medication and the quantity they wanted, and provide information using an online questionnaire. That information would then be passed on to the Pharmacy's GP Prescriber. Once a prescription had been produced, the order would be dispensed and supplied by the Pharmacy.

23. In July 2018, the Council's Inspectors ('the Inspectors') carried out an inspection at the Pharmacy and found it to be satisfactory. At this time the Pharmacy was operating as a limited distance selling pharmacy prescribing and supplying aesthetic products only. A month later, in August 2018, the Pharmacy began selling/supplying high risk medications including medications that required ongoing monitoring, through MyMedsUK.com which used a model whereby the Pharmacy's GP Prescriber was employed to review questionnaires completed by patients online and make prescribing decisions. The Pharmacy then dispensed the prescriptions.

24. In November 2018, the Inspectors carried out a further inspection of the Pharmacy. At that time, there was a locum RP in place who was also a Pharmacist Independent Prescriber ("PIP"). Although the Registrant was not present at this inspection, he did correspond with the Council's Inspectorate in relation to it. The outcome of this inspection was satisfactory, with an action plan which was to be implemented by 25 January 2019. The November 2018 inspection report stated that:

> *"There are no written procedures available in relation to the online prescribing service. This does not meet the requirements of the Responsible Pharmacist regulations and means staff may not always fully understand what is expected of them or where responsibility lies.*
>
> *There is little evidence of risk assessments being completed for the online prescribing service so the pharmacy may not be able to provide assurance that risks have been appropriately identified and managed.*
>
> *Private prescription records are incomplete which does not meet statutory requirements and means the pharmacy may not be able to provide assurance that medicines have been supplied appropriately*".

25. Other issues raised in the November 2018 report included:

- *"…most of the prescriptions ordered from the online prescriber were for medicines that could be misused or abused"*
- concerns about the website
- the structure of online questionnaires

- a lack of information sharing with other healthcare professionals.

26. The report highlighted that the pharmacists at the Pharmacy had access to the online questionnaires in order to assess clinical screening according to their own professional judgements.

27. On 30 May 2019 the Registrant had attended a meeting with the Pharmacy's GP Prescriber and Minutes of that meeting had been provided which indicated discussions had taken place about the introduction of new guidelines for internet pharmacies. The online medication ordering process was discussed and some amendments to it agreed.

28. In September 2019, the Council sent a generic email to all pharmacies, including the Pharmacy, requesting copies of risk assessment documents. The Registrant provided these on 10 October 2019.

29. On 4 October 2019, the Council's Inspectors carried out an unannounced inspection at the Pharmacy. Following concerns noted at this inspection, the Pharmacy's operations were restricted by conditions imposed by the Council on 10 October 2019. The conditions prevented the Pharmacy from selling or supplying any Controlled Drugs ('CDs') from Schedules 1 to 5 of the Misuse of Drugs Regulations 2001 and selling or supplying Modafinil.

30. Evidence collected by the Inspectors indicated that the Pharmacy's Standard Operating Procedures ('SOPs') for operational activities and services provided were vague. The SOPs lacked procedures to manage risks associated with high-risk activities. The Inspectors found that there were insufficient documented SOPs or internal policies outlining the risk management for these higher risk prescribing activities. The Registrant as the SI was responsible for updating the SOPs.

31. The Registrant stated to the Inspectors that no risk assessment was carried out when prescribing Modafinil, a prescription only medication and stimulant for treating narcolepsy. The Registrant stated that he had relied on the Pharmacy's GP Prescriber's professional judgement and that Modafinil had been supplied mostly to students and young people.

32. The Registrant had been involved in the content and design of the online questionnaire and was responsible for how the Pharmacy was carrying out the dispensing in relation to MyMedsUK. The inspection revealed widespread issues in relation to the way in which patients were able to order medication which included:

- Patients being able to select the medicine and quantity they wanted before there had been an appropriate consultation with a prescriber
- Patients being able to change answers to consultation questions on the online questionnaire, without record, to circumvent the system
- A failure by the Pharmacy to require proof of identity from patients
- A lack of information obtained from patients as part of the ordering process
- Insufficient safeguards to ensure supplies of opiates and sleeping tablets were appropriate and these medicines were not being abused or misused.
- The Pharmacy systems did not ensure that patients received the most appropriate medicine for effective treatment.

33. Opioids, Z-drugs and contraceptive medicines (including emergency hormone contraception) were supplied without verifying patients' identity, age or contacting their GPs. While patients were required to register an account with the Pharmacy for services, providing proof of identity was not mandatory. Only 5-10% of new patients were asked to provide identification, and only if an issue arose with their address. The Council found that the Registrant had overseen dispensing of approximately 44,322 prescriptions for high risk medicines and/or medicines that required ongoing monitoring.

34. Patients were able to deliberately enter incorrect information via the Pharmacy's online questionnaires in order to obtain medicines. If a question within the online questionnaire prevented the patient from ordering the medicine, this would be immediately flagged to the patient and the patient could change their response to proceed with the sale.

35. The Council had issued, and updated, Guidance several times in relation to the provision of pharmacy services at a distance. In April 2015, the Council issued '*Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet'*. This was updated in January 2018 to include advice about risk assessments and managing selling and

supplying medicines at a distance safely. The Guidance was updated again in April 2019 and included advice about managing websites, carrying out identity checks and obtaining all the information needed from patients. The April 2019 Guidance listed categories of medicines which were not suitable for online supply without additional safeguards such as medicines liable to abuse, overuse or misuse, or where there was a risk of addiction and ongoing monitoring was important such as opiates and sedatives. Details of additional safeguards to put in place were also listed. The April 2019 Guidance stated the following:

> "*We expect you to make sure you do not work with online providers who are trying to circumvent the regulatory oversight put in place within the UK to ensure patient safety throughout the healthcare system.*
>
> *Working with prescribers who are not appropriately registered with the relevant UK professional regulator, and with prescribing services not based in the UK, could create significant extra risks for patients and the public …..*
>
> *…. We expect you to be able to show how you are assured that all prescribers, whether medical or non-medical, follow the relevant remote consultation, assessment and prescribing guidance…….*
>
> *We expect you to make sure that your website and the websites of companies you work with are arranged so that a person cannot choose a POM and its quantity before there has been an appropriate consultation with a prescriber….."*

Allegation 1

36. The Inspectors found that when patients registered with the Pharmacy's online service, the identity checking system used did not detect potential fraudulent or dishonest activity, or abuse but relied on the vigilance of the prescriber and pharmacy team to detect this from the details provided. Customer services only contacted patients, where their details were not complete or the address did not look correct, to request identification documents before the patient could order a prescription. This happened in approximately 5-10% of new registrations.

Allegations 2 and 11

37. Appropriate safeguards had not been put in place to minimise the risks associated with certain categories of medicines which were liable to abuse, overuse or misuse. The Pharmacy was unable to demonstrate steps taken to identify medicine requests that were inappropriate, too large or too frequent. There were multiple examples of high levels of repeat orders.

Allegations 3 and 5

38. The Inspectors and the Council found that the patient questionnaires used for MyMedsUK were insufficient in gathering data to place before a prescriber. Only 1-2% of patients requesting medications had provided their GP details but medicines were still supplied to those who had not. Messages were sent to some patients suggesting they contact their GP and inform the Pharmacy of the outcome of the discussion next time they placed an order, or they provide details about the management plan agreed with their GP if they wished to order that medication again. However, these messages rarely asked these patients for evidence that this had been done. Where patients had supplied GP summaries, the Inspectors found examples where medical conditions were incorrectly reported. The Registrant, as the SI, had been responsible for ensuring the systems used for online ordering complied with the relevant regulatory guidance.

39. 95% of prescriptions were for opioids and Z-drugs. Patients were prevented from requesting medicines if it was too soon after their previous order, but regular ordering was not prevented or identified as a potential sign of abuse or misuse. Patients were also alerted automatically through the website when they could re-order medication if they had previously been 'locked out'. Medicines containing 30mg of Codeine or Dihydrocodeine could be ordered in packs of 28, 58, 100 or 112. The 'lock out' period was 6, 13 or 27 days. Z-drugs were available in packs of 7 or 14 and the lockout period was 6 or 12 days. There did not appear to be an agreed maximum number of supplies per patient that could be made for each type of medicine.

40. There was evidence that some medicines, such as Modafinil, were available for selection by patients even though they would not normally be appropriate for supply at a distance due to monitoring requirements. Modafinil had been dispensed on 1,285 occasions. In many cases no

proof of ID, address or previous prescription was requested. There were no systems in place to ensure the clinical content of questionnaires were checked regularly.

41. During the October 2019 inspection, the Registrant informed the inspectors that concerns had been raised by family members and by a social worker of people abusing medicines obtained from the Pharmacy. The Inspectors raised concerns that, although 'red flags' were added to individual patient records to prevent future supply, this had not triggered a review to address the risks highlighted on a global level. The Inspectors were also concerned that the patient records did not show examples of the Pharmacy's GP Prescriber setting out his clinical justification for prescribing these medicines for patients who did not have a regular GP, which did not comply with the April 2019 Guidance.

Allegation 4

42. The Inspectors found that patients were able to use the MyMedsUK website to choose a medicine and its quantity before there had been an appropriate consultation with the Pharmacy's GP Prescriber. Patients were also able to change their answers on the online questionnaire if an answer gave a 'negative' response which would not allow supply. The website remained unchanged in October 2019 despite the Inspectors having raising issues about the website at their inspection in November 2018.

Allegation 6

43. The Pharmacy had provided the Council with one formal risk assessment dated January 2019 and copies of Minutes from one meeting in May 2019 between the Registrant and the Pharmacy's GP Prescriber. Following the April 2019 Guidance, updated SOPs were not provided by the Registrant until June 2020.

Allegations 7 and 8

44. During the October 2019 inspection, the Registrant disclosed to the Inspectors that the Pharmacy's GP Prescriber practised in the UK as a GMC registered GP from a surgery in

Northamptonshire, and that the Pharmacy's GP Prescriber also used a desk address in Romania to avoid the need for registration with the Care and Quality Commission ('CQC'). The website MyMedsUK was based in Romania and therefore the Pharmacy's GP Prescriber was working outside the UK regulatory oversight.

Allegations 9, 10 and 12

45. From 1 May 2019 to 30 September 2019, there was evidence that approximately 44,322 orders for high risk medications, or medicines requiring ongoing monitoring, were dispensed by the Registrant on the basis of online questionnaires. Many of these were repeat orders. There was little evidence of information sharing between the Pharmacy's GP Prescriber, or the Pharmacy and the patient's regular GP, or of a review of the patient's medical history by the Registrant. Nor was there evidence that the Registrant had, as the dispensing pharmacist, appropriately clinically checked some prescriptions for safety of supply.

46. The January 2019 formal risk assessment document identified repeat orders as a concern but there was no evidence that steps had been taken to address this. Some patients were able to obtain Z-drugs and opiates on up to 25 occasions, many without any requests for information or for a GP summary, or in the absence of any contact between the patient and the Pharmacy's GP Prescriber, or the Pharmacy.

Allegations 13 and 14

47. In February 2021, an inquest was held into the death of Patient D, who passed away on 9 August 2020. The inquest revealed that MyMedsUK was used by Patient D in 2019 to obtain high risk medication. The Council's investigation identified 3 purchases made by Patient D, with two further purchases said to have been made in the name of her 7-year-old son (Patient E), between May to August 2019. Three payments made to MyMedsUK for the medication for Patient D and Patient E came from the same bank account.

48. The Registrant was the dispenser on 3 May 2019 and 12 July 2019 when 112 tablets of Codeine Phosphate 30mg were dispensed to Patient D. He was also the dispenser on 28 May 2019 when 14 tablets of Zimovane 7.5mg were dispensed to Patient D. The Registrant was also the RP on 14 May 2019 when 112 tablets of Codeine Phosphate 30mg were dispensed to Patient E, and also on 15 August 2019 when Zopiclone 7.5mg was dispensed to Patient E.

49. The Coroner for Cornwall and the Isles of Scilly conducted an inquest into Patient D's death and raised a concern with the Council. In his letter to the Council dated 8 March 2021, the Coroner stated:

> *"What was established in evidence at the inquest was that neither a doctor nor any dispensing pharmacist checked with the registered GP whether it was appropriate to dispense these prescriptions which include opiate medication. Had any check been made, it would have been established that [Patient D] has an opiate addiction and had been struck off the Nursing register for forging prescriptions obtained during her work as a Practice Nurse. It cannot be right that a known addict with a criminal conviction was able to access opiate and other medication without even the most cursory of checks being made to her registered GP."*

Allegation 15

50. During the October 2019 inspection, the Registrant stated to the Inspectors that people were using pharmacy services rather than illegal sources to acquire medicines for inappropriate reasons, and that a pharmacy provided a controlled environment for these vulnerable patients. He stated that if they did not get their medication through a pharmacy, they would go to alternate illegal suppliers like *"the back of an Audi".*

51. The Registrant also acknowledged that Modafinil could be used by students to stay awake during exam revision.

Evidence and Submissions on Misconduct and Impairment

52. Having found all the Particulars of the Allegation proved, the Committee went on to consider whether the Particulars found proved amounted to misconduct and, if so, whether the Registrant's fitness to practise is currently impaired.

53. The Committee took account of the guidance given to the meaning of 'fitness to practise' in the Council's publication *'Good decision-making: Fitness to practise hearings and outcomes guidance'* (March 2024). Paragraph 2.12 reads:

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

54. The Committee took into account the Registrant's evidence, the documents provided and the submissions of both parties.

The Registrant's Evidence

55. The Committee was provided with a statement, documentary and oral evidence from the Registrant. The documents included the Registrant's Reflection Statement, an 'Analysis and Audit of flaws and omissions from the GPhC Guidance', testimonials, his CV and various CPD certificates.

56. In his oral evidence, the Registrant stated that he was truly sorry to all the patients that he had let down and offered his "*deepest and humblest apologies*" to them and to Patient D. He fully accepted all his failings. He said that looking back he had not offered a safe procedure at the Pharmacy, which he regretted and had ultimate responsibility for. He had supplied medications in an unsafe and improper manner.

57. The Registrant provided details of his career history and the nature of his previous roles. He had been working in community pharmacies from 1984 to 2000 and then had management roles for many years - as a Service Development Manager at Alliance Boots (2000-2011) and then Head of Information at Numark Pharmacy (2011-2017). He explained what he had done in each of these

roles – developing new services for patients, disseminating good practice to over 1,000 pharmacies across the country and providing support to pharmacists in response to technical/professional online enquiries about any aspect of the profession. He stated that these positions had been in a corporate environment, were "*desk based*" and were not patient facing roles. He had been *"helping fellow professionals"*.

58. The Registrant stated that from 2017-2019, he became a self-employed consultant advising independent pharmacies on their duties, the relevant rules and policies as well as how to deal with GPhC inspections.

59. The Registrant stated that he applied for the role at the Pharmacy to set up an online pharmacy as *"I love innovation, delivery and successful projects for new types of services and I thought this was a good challenge, I was attracted to it. Looking back it was not a success."* He stated that he had not known the owners, who were brothers and both businessmen, and he had not known that Dr S, the Prescriber, was related to the owners. He had seen an advert for the role in a pharmacy journal but had not known at the time it was for an online pharmacy. This had become apparent from his discussions with a "*middleman*" and he thought *"it was an exciting prospect… The first attraction was it was an innovative way of delivery. I was given a blank sheet of paper to set up an online pharmacy within 6 months."* Prior to joining the Pharmacy the Registrant had considered himself to be an innovator, trying to provide new services. He had not realised the risks involved in setting up an online pharmacy. He saw it as a challenge to deliver services efficiently. He said it may have been pride, or a *"gung ho"* attitude which had made him overlook the patient safety aspects and he had allowed this to undermine his commitment to providing safe and effective dispensing.

60. The Registrant stated that when he joined the Pharmacy the owners were already developing the website with designers. The Registrant had been involved in looking at premises, drafting the SOPs and policies from scratch, and he had designed the patient pathway journey to facilitate patients ordering medication in a safe way. He had not known what medications the owners were planning to sell at that time. They had mainly been supplying aesthetic products within a legacy website which the owners already had. He stated that at the time he did not know where he could get example SOPs for an online pharmacy as the concept was new and the guidance came out after he had written the original SOPs which he had based on templates he already had

for physical "*bricks and mortar"* pharmacies. He stated that he had produced charts and his own plans of what the website should look like but the owners ignored him. The Registrant stated that the owners were keen to supply pharmacy and prescription only products as soon as possible and the Registrant had relied on the first inspection in July 2018 as an indication of a green light to continue. He stated there had been commercial pressure within the organisation on him and he was discussing when they could start supplying pharmacy prescriptions safely.

61. When he saw the website had Prescription Only Medications ('POMs') available to order the following month in August 2018, the Registrant said that he raised concerns with the owners that this was not permitted but they ignored him. The Registrant stated that it was only when the Inspectors advised in November 2018 that POMs could not be sold on the website in the current manner, that the owners accepted they had to make changes to the website. The Registrant stated that the owners ignored other changes that he had suggested such as those relating to repeat prescriptions and maximum quantities that could be supplied in accordance with the relevant licensing regulations.

62. In relation to the identity checks on the website, the Registrant stated that 'Onifido' which was the ID system used by the Pharmacy was based on financial records rather than the standard NHS medical ID checks system now used. He stated that he had tried to implement a better ID check system on the website but had failed due to the way the website had been designed and because the owners and website designers were only interested in his clinical expertise.

63. The Registrant said that he had raised concerns with the owners about the number of repeat prescriptions allowed but had received no response. He stated the owners *"were resistant to change to the website. I didn't like how the questions were written and I was concerned that answers could be changed by patients. I was not comfortable with that. I did not confront the developers or raise it again. I was stuck on an escalator moving at speed and how to get off was not in my mind. I should have stopped the operation."*

64. The Registrant stated he had received no support from the owners who had an expectation that he would deliver services in the shortest time possible. He had received a salary for his work. There were no specific targets to meet but the owners wanted to see a return on their investment. Time had not been set aside for administrative tasks which were incorporated into

his dispensing work hours and prescription orders had to be ready before the couriers arrived in the late afternoon. Prescriptions were only stopped if there was an anomaly.

65. The Registrant stated that he had subsequently asked himself many times why things had gone wrong. He thought that due to his career history, there may have been a sense of pride, which he now felt was wrongly placed, and the sense of failure to deliver a project that had prevented him from leaving the Pharmacy. He said that at the time *"I felt I wasn't doing service to my team as a lot of people were depending on me. These all delayed my thoughts of stopping. I should have stopped … I just think now of the damage I did to patients."*

66. The Registrant stated that after the November 2018 inspection which had set out an action plan, he realised there was lots of work to be done. He accepted the action plan had not been finalised by the time the Inspectors returned in October 2019. He now realised that he should have closed the site down until the remedial work had been done to the processes and the website.

67. The Registrant stated that after the October 2019 inspection, he had realised he had let his patients down, he had supplied medication in an unsafe and improper manner and his situation was untenable. He left the Pharmacy in June 2020. When asked why it had taken him so long to leave, the Registrant stated that he had considered where the Pharmacy was heading, what his role would be and whether he could change things effectively. This had all taken time and he had also been involved in obtaining a wholesaler dealers licence for the business and there were other projects that he was involved in. He stated that the main trigger that had caused him to leave was when the owners had asked him what he was going to do about matters after the October 2019 inspection. He said that he had then realised he needed to leave.

68. In relation to the comments made to the Inspectors at the October 2019 inspection, the Registrant stated that they had arrived unannounced, and he had felt scared, overwhelmed and under pressure by their questions. He stated that he had never been in this situation before even though he had advised other pharmacists on how to deal with GPhC inspections. He regretted making comments to the Inspectors in a candid manner without providing the full context. The Registrant said that he had always been aware of people in vulnerable positions who depended on drugs and would be subject to external influences so would rely on illicit dealers to supply those drugs in an illegal manner. In community pharmacy he had tried to make this safe for them

by proving a needle exchange service and that was the context in which he had made the comments about *"the back of an Audi".*

69. The Registrant stated that he did not agree with people using illicit drugs but it was inevitable that this happened. He said that his comments to the inspectors were about a controlled and legal way to supply these drugs to prevent harm to patients. He said that looking back now, he had handed out drugs within the legal remit of him dispensing from legal private prescriptions. Those drugs had been obtained legally and properly from accredited wholesalers whereas a *"man in a white Audi"* could not do that. He regretted not offering a safe procedure looking back. The Registrant said that at the time he thought he was probably doing a service to stop patients getting illegal drugs but in hindsight, he realised he had been no better than *"a man in a white Audi"* and he felt ashamed of that, even though a doctor had been doing the prescribing. He had not given much clinical thought to the clinical needs of these patients and had been more concerned about getting the medications out quickly and on time. He had relied on the Pharmacy's GP Prescriber to make clinical judgments in allowing the medications to be prescribed and had not challenged this on a regular basis which he regretted. He accepted he had supplied based on want rather than need of the patients.

70. In relation to his comments to the Inspectors about the Pharmacy's GP Prescriber avoiding CQC regulation, the Registrant was ashamed to say that he had been ignorant and unaware of CQC regulations. He had thought that if a GP was already registered under CQC there was no need for a further CQC registration. Because Dr S had been working at a UK GP surgery at the time, he thought he had been working with a trained prescriber registered with CQC. The Registrant said that he had never before been involved in any organisation with CQC oversight and had not been aware of the mandatory importance of CQC accreditation.

71. The Registrant said he had only become aware of the Romania address when the prescriptions started to come through and he had found it surprising. He said that he had asked about this and had been assured it was acceptable. He said that he had mistakenly believed that as Dr S was registered with the GMC, he would be prescribing under that umbrella, so he had ignored the registration requirement. He accepted he had said to the Inspectors that he was aware Dr S was avoiding CQC regulation but he said that he also had not realised it was a mandatory requirement in any prescribing process. On reflection he realised he should have challenged

this, and he regretted not doing so. He accepted this showed a lack of integrity on his part but had since done training on CQC requirements and was aware of how important this regulation was for patient safety. He believed he did have integrity and that part of the situation had been his overall desire to make things right as he had been trying to get to grips with the issues raised by the Inspectors.

72. The Registrant stated that he had been a Pharmacist for many years but had not come across Modafinil before. He said that the owners had offered it on the website and he had not challenged this. After reflection and having educated himself, he had realised the rarity of prescribing Modafinil and accepted he should have stopped this at the Pharmacy. He accepted that at that time, he had been lacking in knowledge about the drug he had been dispensing, although there had been a general consensus that students were using Modafinil to keep awake. The Registrant said that he had been *"enthralled"* by trying to make the system work, without paying due regard to the safety of patients when allowing supply of this drug. This had been an impairment on his part at the time.

73. The Registrant went through his Reflective Statement in detail and explained what he had learnt from this experience and how he would ensure it did not happen again. He talked about the value of face to face consultations with patients, which could not happen with online pharmacies. He explained the importance of understanding patient dependence on high risk medications, checking patient medical histories for diagnosis, assessing clinical needs, monitoring repeat prescription requests, considering alternative medications, communicating with other healthcare professionals involved in the patient's care and ensuring all guidance/regulations are adhered to. He also spoke at length about what he should have done at the time, where he should have asked for support, his lack of insight and professionalism at the time and that he had not been a gatekeeper of medicines as he should have been. He accepted he had allowed unsuitable medications to be supplied to vulnerable patients and acknowledged his failings as a SI and RP at the Pharmacy. He hoped he had addressed his shortcomings and stressed that he deeply respected the patient-pharmacist relationship. His focus now was now always on putting patient safety and well-being first.

74. The Registrant had been working at Boots since 2020 as a high street pharmacist dealing with patients in a deprived area of the country. He said that he found the work very rewarding and

patients would specifically ask to see him. He explained his duties there, how he dealt with patients, what medications he was dispensing, the processes used and how he was doing things very differently now compared to when he had been at the Pharmacy, especially in relation to high risk medications. He explained that he refused medications when appropriate and would offer non-medicinal alternatives where possible. He kept up to date with "*hot topics*" such as weight loss medications. He always placed the patient's interests first. The Registrant stated that 99% of his work was with patients in person and 1% was part of the Boots 'Online Doctor' portal but there were no opiates or high risk medication orders coming through the portal. A doctor was the prescriber and the Registrant was only involved in supply.

75. On further questioning, the Registrant said that he had been aware of the 2015 Guidance but it had been very basic and did not take account of the enormous demand from patients. He said that he had been aware of the 2018 and April 2019 Guidance but had been concentrating on setting up the dispensary process so had not been fully conversant with the content of these. He accepted he had overlooked the provision that advised pharmacists against working with prescribers registered abroad who may be seeking to avoid UK regulation. He accepted with hindsight, this had been crucial.

76. The Registrant accepted that, on reflection, he had provided medications in a transactional manner and this was likely to cause harm. He accepted that he had thought the supply of CDs was high but he had not thought about the implications of supplying such quantities at the time. He said that there had been a few patients where GPs had been contacted and had not agreed to the prescription so it had not been supplied. The Registrant stated that he had looked at the amounts that could be taken daily under the medicines licencing agreement and would dispense if within that allowance. He agreed that he had failed at the time. The Registrant accepted he had been complacent and not exercised proper scrutiny and diligence over processes after red flags were raised by GPs asking the Pharmacy not to supply.

77. The Registrant accepted that there were no documents to evidence the changes he had been trying to implement. He said that he had sent emails to the Pharmacy's GP Prescriber about processes and the Pharmacy's GP Prescriber had been involved in drafting the online questionnaire. The Registrant regretted not challenging the Pharmacy's GP Prescriber and did not know why he had not done so at the time. He said that with hindsight he wished he had had

the strength, authority and knowledge to do all the things he had not done. He assured the Committee that this experience had taught him that patient safety was the most important thing and authority must be challenged if there are concerns. He explained that even now if his employer were to set unrealistic targets, he would challenge them on the basis of patient safety and well-being over money.

78. The Registrant accepted that members of the public would be appalled to hear that patients had been able to get medications so easily from the Pharmacy without proper checks and balances. They would be most disappointed that a trained professional like the Registrant could be involved in medicines being obtained in such a transactional way.

79. The Registrant stated that he did not think that there was currently a safe way which would also be commercially viable to supply online pharmacy services. He confirmed he did not wish to be involved in online pharmacy services again in the present form. He said he had learnt from his mistakes, undertaken training and implemented what he had learnt. He felt he would now be an asset in providing good safe pharmacy care.

Submissions

80. Ms Manning-Rees relied upon her Skeleton Argument and submitted that as both SI and RP, the Registrant had the overarching responsibility for the clinical governance of the Pharmacy to ensure that the systems, processes and policies for the prescribing and dispensing of medications were safe and effective. She submitted that many of the issues had previously been highlighted to the Registrant during the November 2018 inspection but he had allowed an unsafe system to continue to function without meaningful risk assessments and audits being carried out. Ms Manning-Rees confirmed that Dr S, who had been the Pharmacy's GP Prescriber, had made admissions to his own regulator about unsafe prescribing practices.

81. Ms Manning-Rees accepted that the expert report from Dr Campbell was less relevant to the Registrant as it dealt with prescribing rather than dispensing to patients and she confirmed it had been provided to the Committee for contextual purposes.

82. Ms Manning-Rees also confirmed that there was a '*legal loophole'* which had allowed Dr S to register outside the UK to issue prescriptions from Romania, thereby avoiding CQC regulation in

the UK. However, she reminded the Committee that the April 2019 Guidance advised pharmacists to avoid working in such arrangements.

83. Ms Manning-Rees further submitted that it was not the Registrant's role to try and make the supply of high risk drugs safer by effectively commercialising legalised drug dealing. She submitted the Registrant had done admirable reflection but there was more to be done. She submitted his integrity could not be relied upon due to the disconnect in his answers about Dr S and why he had not challenged that behaviour.

84. Ms Manning-Rees submitted the Registrant's conduct was seriously reprehensible and amounted to misconduct. She referred the Committee to the case of Roylance v General Medical Council (No.2) [2000] 1 A.C. 311 which stated:

> *35. "Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed.....in the particular circumstances.*

85. Ms Manning-Rees also referred the Committee to a number of other cases including Meadow v General Medical Council [2007] 1 All ER 1, in which Auld LJ stated:

> *"200……. As to seriousness, Collins J. in Nandi v General Medical Council [2004] EWHC 2317 (Admin), rightly emphasised at [31] the need to give it proper weight, observing that in other contexts it has been referred to as 'conduct which would be regarded as deplorable by fellow practitioners'."*

86. Ms Manning-Rees submitted the Registrant's conduct had shown a disregard for the role pharmacists hold in safeguarding pharmacy services for the health, safety and wellbeing of the public. She submitted he had an attitudinal deficiency in how he operated the Pharmacy and his own dispensing practice. She submitted he had been indifferent to the dangers present in simply dispensing medications without any attempt at legitimate oversight and this amounted to the commercialised supply of prescription only medicines.

87. Ms Manning-Rees made it clear that the Council did not allege any financial motive on the part of the Registrant and nor did it allege that he had any responsibility for the death of Patient D, which had occurred many months after the dates of supply.

88. Ms Manning-Rees submitted there had been a breach of Standards 1, 2, 3, 5 and 9 of the GPhC Standards for Pharmacy Professionals 2017 ('the Standards') and it was plain that the Registrant's conduct amounted to misconduct.

89. In relation to impairment, Ms Manning-Rees submitted there had been a breach of Rule 5(2)(a), (b), (c) and (d) of the Rules and that the Registrant was currently impaired.

90. Mr Hadley, on behalf of the Registrant, reminded the Committee that the Registrant had not been the Prescriber in this case and the allegations were made on the basis that he had been the supplier of medications. He stated that the Registrant accepted the seriousness of the case but the fact that he was not the Prescriber was also relevant. Mr Hadley submitted the dates of the actual allegations were quite narrow, from 1 August 2018 to 11 October 2019 and the Registrant had made admissions and co-operated throughout.

91. Mr Hadley also referred the Committee to the regulatory decision concerning Dr S, who had been the Pharmacy's GP Prescriber, where conditions had been imposed upon him by his own regulator. Mr Hadley accepted this Committee was not bound by that decision but submitted that the Registrant had been given legal authority to supply medication as a result of Dr S's prescribing. He pointed out that Dr S had been acting lawfully when he used a Romanian address to prescribe for the Pharmacy. Mr Hadley submitted Dr S had been in a position of seniority but stressed that, despite this, the Registrant was not resiling from his own responsibilities. The Registrant accepted that he should have understood the nature of the drugs being prescribed and should not have been a '*yes man*' to Dr S. The Registrant appreciated that his own dispensing activities should have been safe, he should have been conducting his own checks and he had failed to do so.

92. Mr Hadley submitted that online pharmacies had been a new area of practice at the time and this was reflected in the developing guidance from the Council. He also submitted Dr Campbell's

report was generic, aimed at prescriber practices and did not address the specific details of this case. The report also relied heavily on Guidance after 2020 which was not applicable in this case.

93. Mr Hadley submitted that the Registrant had sufficiently remediated what had gone wrong and that not all allegations amount to misconduct, although the Registrant accepted the Committee was likely to find misconduct. The Registrant had shown insight, fully accepted responsibility and although he had accepted his actions in relation to Dr S's Romania desk prescribing lacked integrity, this had been a lawful practice. There had been two satisfactory inspections before October 2019.

94. In relation to impairment, Mr Hadley submitted very serious misconduct could be remediated, including behavioural issues. He stated that the Registrant conceded that at the time of the allegations, Rule 5(2) (a)-(d) were all engaged but they had all now been addressed and remediated. Mr Hadley reminded the Committee that the Registrant had previously had a faultless impressive 34 year career, and after these events, had worked for a further five years with no concerns. He had made full admissions, had apologised, shown remorse, demonstrated remediation and undertaken training. Mr Hadley reminded the Committee that if it did not find impairment, it could still issue a warning to the Registrant.

Decision on Misconduct

95. When considering whether the Particulars of the Allegation found proved amounted to misconduct the Committee took into account the *Good Decision making guidance*.

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

a. Standard 1 – Pharmacy Professionals must provide patient centred care.

   The Committee had no doubt that the Registrant had failed to provide patient centred care. He had made multiple admissions of failing to provide safe and effective care to patients in a number of ways.

b. Standard 2 – Pharmacy professionals must work in partnership with others.

The Registrant had also admitted a failure to contact patients' GPs in relation to the vast majority of patients. He had relied solely on the content of the online questionnaires and the prescriptions which contained a limited order history. Nor had he challenged the Pharmacy's GP Prescriber in relation to the justification for prescriptions especially those which related to repeated high risk medications. The Registrant had failed to contact GPs after medications had been supplied and instead had relied on patients to voluntarily discuss matters with their GP and report back to the Pharmacy if further medication was to be ordered. There was a lack of ensuring continuity in care by collaborating with appropriate healthcare professionals.

c. Standard 3 – Pharmacy professionals must communicate effectively.

The Registrant had not communicated with patients directly at all, relying on the online questionnaires, answers which he knew could be changed if the order was refused due to the nature of an answer. There was no real exchange of information and patients' clinical needs were not a consideration in his dispensing. He oversaw a system where patient medical records were not properly checked by the Pharmacy's GP Prescriber, patient consultations did not take place and there was no real risk assessment particularly in relation to high risk medications.

d. Standard 5 – Pharmacy professionals must use their professional judgement.

On his own admissions, the Registrant had failed to use his professional judgement on multiple occasions. He accepted he had not made patient care his primary concern and that he had failed to act in patients' best interests. He had not used either his clinical or his professional judgment when dispensing and supplying medications and had admitted he had acted with a lack of integrity by not challenging Dr S's prescribing from a Romania desk. It was clear from the Registrant's evidence that the needs of the business owners had been placed above everything else and his judgement had been clouded by his focus on the organisational goals of the business rather than the needs of patients. Even when he was meeting resistance from the Pharmacy owners about changes, he wished to implement, he still allowed the website to continue operating despite his reservations.

e. Standard 9 – Pharmacy professionals must demonstrate leadership.

The Registrant, on his own admissions, had failed to lead on a pioneering project to ensure he had done everything he could to keep the risks to patients as low as possible. He had failed to properly read and follow the guidance in place in relation to pharmacies providing pharmacy services online. He had failed to insist to the owners that various safeguards must be implemented to ensure that high risk medications being ordered online were being properly controlled and not subject to abuse, overuse or misuse. Critically, when he realised that his concerns were being ignored, he remained at the Pharmacy after his recommended changes were not implemented.

97. 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).

98. This was a case that the Committee considered to be very serious. Although the Registrant was not the Prescriber and relied upon the Pharmacy's GP Prescriber to make clinical decisions about whether to issue prescriptions, he still had a duty as a pharmacist to ensure medication was being supplied safely and effectively. He had failed to place patient safety first and his dispensing and supply was almost entirely transactional in nature as numerous safeguards which should have been in place were not implemented. The Registrant, on his own admission, had allowed himself to be distracted by the bigger picture of the innovation of delivering an online pharmacy service and that seemed to have overtaken all other considerations. On the few occasions when patients' GPs were contacted, those GPs requested medication should not be supplied. Whilst this was adhered to by marking the relevant patient's records, the Registrant had not conducted a global review of other changes that could have been put in place to protect other patients.

99. The Committee concluded there had been multiple failures by the Registrant over a period of 14 months during which time the Registrant had not focussed on patient safety and the fundamental principles of pharmacy, which applied regardless of whether pharmacy services were being provided in person or online. Approximately 44,322 high risk medications or medicines that required ongoing monitoring had been supplied under the oversight of the Registrant. There had been little, if any, consideration of medication dependency or misuse. The dispensing of Modafinil at the very least should have alerted the Registrant, given that throughout his previous 34-year career, he had never come across this medication. Yet despite

this, whilst at the Pharmacy, he did not question the high number of prescriptions for it despite its rarity in being prescribed.

100. The Registrant had not adequately challenged the Pharmacy's GP Prescriber using a Romanian address for prescribing, although the Committee did take into account that this prescribing was legitimate and had been done within the legal framework in place. The Council had accepted this was a legal loophole and meant that that prescribing did not fall within the regulation of CQC. However, in such circumstances, proper processes, procedures and policies within the Pharmacy, which the Registrant had been responsible for as the SI, were even more important but had not been adequate. He had also allowed the owners of the Pharmacy, who did not appear to be regulated professionals, to continue to use him as the SI and RP whilst ignoring his suggestions to address the risks that he had raised with them such as poor ID checks, monitoring repeat high risk medication orders, and concerns about patients being able to change answers to questionnaires to circumvent a negative response to an online order.

101. The Committee concluded that members of the profession would consider the Registrant's conduct to be deplorable. His conduct was serious and had fallen far short of what would have been proper in the circumstances. The Committee had no doubt that the Registrant's conduct amounted to misconduct.

102. Accordingly, the Committee concluded that, in its judgement, the ground of misconduct is established. The Committee therefore went on to consider whether the Registrant's fitness to practise is currently impaired.

Decision on Impairment

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

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

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

(c) has breached one of the fundamental principles of the profession of pharmacy

(d) means that the integrity of the Registrant can no longer be relied upon.

104. The Committee was satisfied that Rules 5(2)(a), (b) and (c) were engaged in this case. There was no evidence of actual harm to patients due to the Registrant's conduct, but he had presented a potential risk to patients by failing to ensure proper processes and procedures were in place to minimise the risks involved in the dispensing and supply of high-risk medications liable to abuse, misuse and overuse by patients using online pharmacy services. Indeed, he had accepted this. The Registrant had not been the Prescriber in this case but had failed in his duties, as the SI and RP, to have proper oversight of the medications being dispensed and supplied to patients ordering them online. His role in dispensing and supplying medications from online orders was transactional with little focus on patients' clinical needs. There had been a failure on the part of the Registrant to exercise effective oversight of this process notwithstanding a GP was doing the prescribing.

105. As a result, the Registrant had brought the profession of pharmacy into disrepute. Complaints had been received from a Coroner about the failure of pharmacists to check with the registered GP whether it was appropriate to supply Patient D, who had an opiate addiction, with opiate medication. Complaints had also been received from a social worker and family members relating to the misuse of medication by patients who had obtained medication from the Pharmacy.

106. The Registrant had also breached a number of the fundamental principles of pharmacy - he had not protected, promoted and maintained the health, safety and well-being of the public by allowing patients to be able to obtain medications, particularly high-risk medicines, from the Pharmacy with little scrutiny or challenge. He had not maintained public confidence in the profession as he had not addressed the risks which would prevent the abuse, misuse or overuse of high-risk medications supplied by the Pharmacy. He had failed to maintain proper professional standards and conduct expected from pharmacy professionals as he had not familiarised himself fully with the relevant guidance in place at the time, he had not implemented the necessary processes and procedures to protect patient safety and well-being and he had breached Standards 1, 2, 3, 5 and 9.

107. Finally, in respect of Rule 5(2)(d), the Registrant had admitted he had acted with a lack of integrity in relation to Allegation 7. This was a narrow allegation in that it related only to working

with Dr S, who was the Pharmacy's GP Prescriber, while knowing that Dr S was circumventing regulatory oversight by the CQC. The Committee had been informed that this was legal. The Registrant had stated that in hindsight, he had been told the arrangement was *"OK"* but felt that he should have challenged it further and wished he had done so. He did admit that he had not been aware of the April 2019 Guidance which stated that pharmacists were expected to make sure they did not work with online providers who were trying to circumvent the regulatory oversight put in place within the UK. That Guidance seemed to be aimed mainly at prescribers who were not registered with a UK professional regulator. Dr S was regulated by the GMC and appeared to have exploited a legal loophole allowing him to prescribe from a Romania address even though he was working with a UK GP practice. Those copies of prescriptions provided to the Committee had his GMC registration number on them which implied he was prescribing as a UK registered GP. The Committee concluded that as the Registrant had admitted a lack of integrity on this issue, Rule 5(2)(d) was engaged.

108. The Committee then considered whether:

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

109. The Committee was satisfied that the conduct found proved could be addressed, and the Registrant had taken steps to address it. He had made admissions to all the Allegations. He had also apologised to the patients involved. In his evidence the Registrant had shown genuine contrition, remorse and insight. It was clear that he had learnt a hard lesson from his mistakes. He had addressed each aspect of the Allegations in detail both in his Reflective Statement and in his oral evidence. He understood where, how and why he had fallen short, what he should have done differently and he had explained what he had done since then as well as what he would do in future. The Registrant's Reflective Statement was comprehensive and included an analysis of

each of his flaws, an action plan and a drug review of medicines that had presented the most harm to the public which included opioids, Z-drugs and Modafinil.

110. The Registrant had provided evidence of the Continuing Professional Development courses that he had attended from 2020 to January 2024. These included courses on 'Clinical history taking', 'Risk Management', 'Substance use and misuse' and 'Safeguarding children and vulnerable adults'. The Registrant had spoken at length about how he had applied his reflections and his learning to his current pharmacist role.

111. The Committee had also been provided with testimonials, two of which were from the Registrant's Line Managers at Boots where he had been working since 2020. All the testimonials spoke highly of the Registrant's professionalism and integrity, and his enthusiasm for patient care and patient safety. His current manager Mrs E had stated: "*Many patients come and ask for him by name… I have never worked with a pharmacist who is such an integral part of the local community as he is… Gary goes the extra mile with patients… We see every day how he acts with integrity and professionalism"*.

112. Whilst a lack of integrity could be attitudinal, and could be difficult to address in some cases, the Committee, having taken into account all the circumstances relating to Allegations 7 and 8, and having heard evidence from the Registrant, was satisfied that his integrity could now be relied upon. The position concerning Dr S was in fact legally allowed and the Committee accepted the Registrant's assurances that he would not work in such an environment again. The Registrant had shown deep reflection and insight into his misconduct. He had admitted all his failings without seeking to place the blame on others, and he had shown genuine shame and embarrassment about allowing himself to be distracted by commercial goals rather than keeping his focus on patient safety. The Committee took into account that he had been in managerial/consultancy roles without patient contact from 2000 to 2019 before he joined the Pharmacy and he had now realised that he had focused too much on the operational delivery aspect of his new role rather than the pharmacist-patient relationship. The Committee was satisfied that the Registrant would not allow himself to become involved in a similar situation again and that he had learnt his lesson. He gave an example of where he would successfully

challenge his current employers in relation to unrealistic targets which could compromise patient care.

113. For all these reasons, the Committee concluded that the Registrant no longer presented a risk of harm to patients or the public and the risk of repetition of the Registrant's conduct was low. The Committee concluded that his fitness to practise was not currently impaired on public protection grounds.

114. The Committee went on to consider whether a finding of current impairment was required in the public interest. There was no doubt that the misconduct was serious. Members of the public would be shocked to learn that such large volumes of high-risk medications were being dispensed and supplied in a transactional nature by the Registrant at the Pharmacy, thereby potentially placing vulnerable patients at risk of harm. Such conduct was not acceptable, and the Committee concluded that a finding of current impairment is required to mark the seriousness of the misconduct. A finding of current impairment is also required to declare and uphold proper standards of behaviour and make clear to other pharmacy professionals what is expected of them as well as deter them from failing to meet such standards. A finding of current impairment is required to maintain public confidence in the profession as members of the public would expect the regulator to make such a finding in these circumstances.

115. The Committee found that the Registrant's fitness to practise is currently impaired on public interest grounds.

116. The Committee therefore went on to consider the issue of sanction.

Sanction

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

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

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

120. The Committee took into account the submissions made by Ms Manning-Rees and Mr Hadley.

121. Ms Manning-Rees submitted that the appropriate sanction in this case was a Suspension of 6 months with no review given the Committee had found the Registrant was not a risk to the public. She submitted such a sanction would reflect the seriousness of the conduct. She referred the Committee to her Skeleton Argument which set out the aggravating factors for the Committee to consider.

122. Mr Hadley made detailed submissions on sanction taking the Committee through what he considered to be the mitigating factors in this case. He submitted that many of the relevant mitigating points had already been part of the Committee's decision on impairment which had found that the Registrant did not pose a risk to the public. He reminded the Committee that it should impose the minimum sanction necessary to maintain public confidence, declare and uphold standards and mark the seriousness of the Registrant's conduct. This was not a case where the public needed protecting and the purpose of sanction was not to punish the Registrant for his previous wrongdoings. Mr Hadley accepted the public interest weighed higher than that of the Registrant but reminded the Committee it must also balance the Registrant's interest when imposing a sanction which should be the minimum necessary and proportionate. He advised the Committee that the Registrant (REDACTED) and would suffer financially if he was unable to work.

123. Mr Hadley submitted that the owners of the Pharmacy had walked away *"with pockets full of money"* and submitted the public would be sympathetic to the position the Registrant had found himself in. Mr Hadley also reminded the Committee again that Dr S, the Pharmacy's GP Prescriber, had been dealt with by way of conditions and had not been taken out of practice by

his regulator. He accepted the Committee was not bound by the decision of another regulator. In this case the Registrant was not the Prescriber and Mr Hadley submitted that lessened the Registrant's culpability.

124. Mr Hadley submitted the Registrant's attitude and behaviour were also important and the Committee should take into account how he had conducted himself during the Council's investigation and during these disciplinary proceedings. He had co-operated and participated fully throughout and that demonstrated his understanding into his conduct which should also lessen the severity of any sanction to be imposed.

125. The Committee had already given a detailed determination on impairment and took those matters into account during its deliberations on sanction. The Committee first considered what, if any, aggravating and mitigating factors there may be in this case.

126. The Committee identified the following aggravating factors:

a. Large volumes of high-risk medications were being repeatedly dispensed and supplied by the Registrant in a transactional nature thereby potentially placing vulnerable patients at risk of harm through the abuse, misuse or overuse of those medications.

b. The Registrant's conduct took place over a period of 14 months, and he did not adequately respond to concerns raised by the Inspectors or take effective action in relation to the action plan in a timely manner.

c. The Registrant did not properly consider and fully implement the relevant Guidance available.

127. The Committee identified the following mitigating features:

a. The Registrant had made admissions to all the Allegations and had accepted full responsibility for his misconduct. He gave evidence in a candid and open manner, not seeking to blame others for his own shortcomings and accepting full responsibility for his role at the Pharmacy.

b. There was no evidence of actual harm to patients.

c. The Registrant had a previously long unblemished record of 34 years as a pharmacist.

d. The Registrant had continued working as a pharmacist for a further 4 years after the conduct with no further complaints.

e. The Registrant's actions were not financially motivated.

f. The Registrant had co-operated with both the Inspectors and the regulatory proceedings throughout, and he had provided documents which the Council later relied upon.

g. The Registrant had demonstrated genuine insight, remorse and regret, making sincere apologies to all the patients who may have been impacted.

h. The Registrant had addressed his shortcomings by demonstrating comprehensive remediation. He had analysed his failures in detail and set out what he had learnt in his reflections. He had completed CPD courses relevant to a number of the concerns raised about patient safety and he had spoken at length about what he would do differently in the future.

i. Good testimonials were provided speaking highly of the Registrant's work as a pharmacist covering the period both before and after the conduct at the Pharmacy. All the referees were healthcare professionals who were aware of the Allegations and had described the Registrant's expertise and skills as a pharmacist as of value to patients and to the Pharmacy profession.

128. The Committee also took into account that the concept of online pharmacy was in its infancy at the material time and a developing area. This was evident from the fact that over this period the Council had also updated its own guidance relating to pharmacy services at a distance including on the internet. The Registrant had spoken of his desire to implement a new service for the benefit of patients and the Committee accepted that he had genuinely wished to deliver an effective online service. However, it was also relevant that the Registrant had been in a corporate environment in managerial roles for some 19 years before joining the Pharmacy. In those positions he had not been in a patient facing role, but he had been involved in disseminating good practice and advice to other pharmacy professionals, yet when he joined the Pharmacy, he did not make himself fully conversant with the relevant Guidelines in place. He had candidly accepted this had been a critical error on his part.

129. The Committee also considered that another important factor was that the Registrant was not the Prescriber in this case and had relied heavily on the judgement of the Pharmacy's GP Prescriber who was registered with the GMC. This did not detract from the Registrant's own responsibility as a gatekeeper of high-risk medications but it was relevant to his overall culpability. He had, however, shown deep insight into his role as the supplier of medications and the Committee had found there was a low risk of repetition.

130. The Committee then considered whether it would be appropriate to take no action but concluded that would not mark the seriousness of the conduct in this case.

131. The Committee considered whether a Warning would be the appropriate sanction. The *Good Decision making guidance* stated that a Warning could be relevant where

> "*there is a need to demonstrate to the professional, and more widely to the public, that the conduct or behaviour fell below acceptable standards. There is no need to take action to restrict a professional's right to practise, there is no risk to patients or to the public, but there needs to be a public acknowledgement that the conduct was unacceptable.*"

132. The Committee, having considered the specific facts of this particular case and for all the reasons given above, was satisfied that a Warning would be sufficient to mark the seriousness of the misconduct, declare and uphold proper standards of behaviour and maintain public confidence in the pharmacy profession. The Committee had no doubt that the Registrant had learnt a very salutary lesson from his experience at the Pharmacy and had done all he could to remediate his misconduct. He had been ashamed, embarrassed and shown genuine contrition about his behaviour. The Committee was satisfied that informed members of the public, knowing the full facts of this case, would consider a Warning, which would remain on the Registrant's record for 12 months, to be a sufficient sanction to meet the public interest. The Committee concluded it would not be in the public interest to deprive the public of a good pharmacist, particularly as the Registrant had worked well with no issues over the last 4 years, and prior to the misconduct, he had been in practise for 34 years with no concerns.

133. The Committee decided that in this particular case, restricting the Registrant's ability to practise would not be proportionate and would be overly punitive. In any case, the Committee could not identify any conditions that could be imposed as the Registrant was not considered to be a risk to

the public. Similarly, the Committee was satisfied that a suspension in this case would be disproportionate and punitive on the Registrant taking into account the significant mitigating factors it had identified. A Suspension was more than what was the minimum required to meet the public interest in this case.

134. The Committee therefore imposed the following Warning:

> *The Committee warns the Registrant as follows:*
>
> *The Committee has found, by your own admissions, that your actions amounted to a serious failure to meet the Standards for pharmacy professionals, in particular it has found that you breached Standards 1, 2, 3, 5 and 9 and you failed to adhere to the GPhC 'Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet' (Updated January 2018 and April 2019).*
>
> *Your conduct was unacceptable and fell below the standard expected from a registered pharmacy professional. Your actions brought the profession of pharmacy into disrepute and breached some of the fundamental principles of the pharmacy profession.*
>
> *You have remediated your misconduct and do not pose an ongoing risk to the public. You have been found to be impaired in the wider public interest of marking the seriousness of your conduct, declaring and upholding proper standards of behaviour and maintaining public confidence in the profession.*
>
> *The Committee having heard your evidence and considered your documents and representations is of the view that a warning is required to stand as a reminder to you and to other pharmacy professionals of the importance of meeting the Standards required of pharmacy professionals at all times. Failing to do so may negatively affect the reputation of pharmacy professionals and must not be repeated.*
>
> *In particular, if you decide to embark on a new area of pharmacy expertise or service, you should first carefully consider and undertake the appropriate training and familiarise yourself fully with the relevant guidance so that you meet the standards expected of pharmacy professionals to ensure the safe and effective provision of pharmacy services.*
>
> *This warning will be published on the register against your name and will be available for 12 months. If you do not comply with this warning, it may be taken into consideration by an Investigating or Fitness to Practise Committee in the future.*

135. This concludes the determination.