General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote video-link hearing

Monday 8 – Wednesday 10 April 2024

Monday 28 - Thursday 31 October 2024

Registrant name:	Thomas Cave
Registration number:	2216999
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Alastair Cannon (Chair)
	Gazala Khan (Registrant member)
	Nalini Varma (Lay member)
Legal Adviser:	Mary-Teresa Deignan
Committee Secretary:	Adam Hern
Registrant:	Present and represented by Alecsandra Manning-Rees of Counsel.
General Pharmaceutical Council:	Represented by Gareth Thomas, Case Presenter
Facts proved:	4 & 5
Facts proved by admission:	1, 2, 3,
Facts not proved:	None
Fitness to practise:	Impaired
Outcome:	Removal from the register
Interim measures:	Imposed

Particulars of Allegation (as amended)

You, a registered Pharmacist whilst working as the Responsible Pharmacist at Jhoots Pharmacy, 65 Raddlebarn Road, Selly Oak, Birmingham, West Midlands, B29 6HQ,

1. On one or more occasions between 1 February 2022 and 30 June 2022 you failed to maintain accurate and/or up to date records in the Controlled Drugs Register.

2. Between 14 February 2022 to 31 March 2022 for one or more patients you failed to dispense the correct measure or titration of methadone.

3. Between 14 February 2022 to 31 March 2022 failed to endorse one or more FP10MDAs with the amount of methadone dispensed.

4. Between 19 March 2021 to 18 November 2021 on up to 23 occasions dispensed a mixture of POMs, including Schedule 3 and 5 drugs within Schedule A, to yourself in circumstances where there was no prescription against which to dispense the POMs.

5. Your actions in paragraph 4 above were dishonest in that:

5.1. You knew there was no valid prescription issued against which medicines could be dispensed to you;

And/or,

5.2. You knew that you were not entitled to remove these medicines as they were not prescribed for you.

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

<u>Schedule A</u>

Aciclovir 800mg tabs

Atorvastatin 40mg tabs

Avomine 25mg tabs

Cefalexin 500mg tabs

Ciprofloxacin 750mg

Co-codamol 30mg/500mg caplets

Diazepam 10mg tabs

Freestyle lancets 0.5mm/28g

GSF-syrup oral gel mixed flavours 18g sachets

Loperamide 2mg caps

Macrobid MR 100mg caps

Morphine sulfate 10mg/5ml oral solution (500ml)

Orlistat 120mg caps

Paracetamol 500mg caplets

Ramipril 1.25mg caps

Ramipril 2.5mg caps

Ramipril 5mg caps

Tramadol 50mg caps

Trimethoprim 100mg tabs

Zydol Soluble 50mg tabs (100

Documentation

Document 1- GPhC hearing bundle, received in advance

Document 2- GPhC skeleton argument, received in advance

Document 3- Registrant's bundle, received in advance

Document 4- Addendum statement, with exhibits, to the Council's witness's original statement, subject to an application and admitted into evidence at the outset of the hearing

Document 5 – A copy of the determination dated 25 March 2024 by the GPhC's Investigation Committee in respect of a warning delivered by them to Ms Shah, the Superintendent of Jhoots Pharmacy, which was subject to an application to be admitted by Ms Manning- Rees.

Document 6 - An image of two till receipts from the Pharmacy, subject to an application and admitted into evidence at the outset of the hearing.

Document 7 – A copy of a document within Document 4 but with some redactions removed, at the request of the Committee received in evidence during the hearing.

Document 8 – Further documentation and training record in respect of the Registrant during his employment with Jhoots, requested by the Committee and received in evidence during the hearing

Witnesses

Ms 1, Superintendent Pharmacist (‘the SI’) for Jhoots Healthcare Limited (‘Jhoots’I) - gave evidence at the facts stage.

The Registrant elected not to give evidence at the Facts stage.

Determination

Introduction

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

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

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

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

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

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

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

5. A Principal Hearing has up to three stages:

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

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

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

Service of Notice of Hearing

6. The Committee has seen a letter dated 27 February 2024 from the Council headed 'Notice of Hearing' addressed to the Registrant. The Committee was satisfied that there had been good service of the Notice in accordance with Rules 3 and 16.

Application to amend the particulars of allegation.

7. The Committee heard an application from Council Case Presenter under Rule 41 to amend particulars, seeking to both restructure them and make specific an allegation of dishonesty.

8. The Case presenter told the Committee that on 1 March 2024 the Council wrote to the Registrant's representatives, shortly after the Notice of Hearing was sent to the Registrant containing the original allegations, giving notice of its intention to apply to amend the

allegations. The proposed amended allegations appear in the bundle. The Case Presenter submitted that the amended allegations are designed to reflect better the evidence and to make explicit an allegation of dishonesty, detailed at allegation 5, that may otherwise be implicit in the facts of the unamended allegations, and to avoid under-prosecuting. He submitted that on 26 March 2024 solicitors acting for the Registrant served on the Council a witness statement from the Registrant within the defence bundle. In this statement, it was submitted, the Registrant had addressed himself to the allegations as it is proposed they be amended, and that the allegations had from the outset contained an allegation of self-dispensing without a valid prescription.

9. The application to amend the allegations was not opposed.

10. The Committee noted that it was unusual to hear an application to add an allegation of dishonesty at such a late stage when there had been no new or additional evidence presented in support of the proposed amendment. However, the Committee noted that the unamended particular of allegation did contain within it an implicit suggestion of wrongdoing which might amount to breaches of the standards relating to integrity and honesty.

11. The Committee noted that the proposed amendment would allege dishonesty, but did not also allege a lack of integrity, and asked the Case Presenter, Mr Thomas, whether this was a deliberate decision. The Committee was informed by Mr Thomas that the case had been reviewed by a senior Council lawyer and following that review the amendments submitted were only those sought.

12. The Committee accepted in full the legal advice received.

13. The Committee determined that it would be fairer to both parties if the allegations were amended as proposed so that they did not contain only an implicit suggestion of dishonesty. If such was the Council's case on the facts found proved, then, the Committee determined, it would be better if alleged dishonesty was to be put directly to the Registrant and that he be given the opportunity to directly admit or refute such an allegation, and to ensure that there was not undercharging: undercharging would not be in the public interest. The Committee noted that the application was not opposed. The Committee noted also that the Registrant had addressed himself to the issue of dishonesty in his witness statement, so that no unfairness to him would arise from amending the allegations at this juncture.

14. Accordingly, the Committee acceded to the application to amend. The original allegations are appended at Appendix 1 for completeness.

Application for the hearing to be held in part in Private.

15. The Committee heard an application from the Registrant's representative, Ms Manning-Rees, under Rule 39(3) to hold parts of the hearing in private in order to protect the privacy of the Registrant when matters relating to his health and family life were being discussed.

16. The Council's Case presenter did not oppose the application.

17. The Committee accepted the advice of the Legal Adviser.

18. The Committee decided to hold certain parts of the hearing in private if and when there are references to matters of the Registrant's health or family life. The Committee determined that it would be likely that there would be discussion of matters of health which had been referred to in the Registrant's written statement as being a matter of relevance in the case. The Committee determined that it was satisfied that the interest of the Registrant in maintaining his privacy outweighed the public interest in holding the entirety of the hearing in public. Allowing discussion in private of those any health matters would help ensure those giving evidence on this matter would not be inhibited from doing so fully and openly. The Committee did not consider that there was any public interest in making public the specifics of the Registrant's health.

19. Accordingly, the Committee acceded to the application to hold relevant parts of the hearing in private.

20. The Committee noted that there was a single observer present who was described as a senior Council officer who was observing the hearing in relation to her role at the GPhC in the Fitness to Practise team. It was submitted by the Council's Case Presenter that such a person would be well aware of, and bound to observe, the requirements of confidentially. The Registrant was asked whether he would be content for the observer to remain during any parts of the hearing heard in private. The Registrant stated he would be content that she did so. There was no application to allow the observer to observe the Committee *in camera*, and she did not do so.

First Application to admit further evidence

21. The Council made an application under Rule 18(5) to admit further documentation – Document 4 - into evidence. These documents comprised an addendum statement consisting of 12 paragraphs, dated 5 April 2024, by the Council's witness, Ms 1, the SI of who had conducted the internal investigation, along with a number of exhibits relating to the medication and stock ordering system in the Pharmacy and training said to have been undergone by the Registrant during his time at Jhoots. There were 79 pages of exhibits comprising:
    - A document titled 'Your Onboarding Programme' which was a manual covering a number of practical matters including the ordering of stock using the system the Pharmacy;

- Numerous screenshots taken by Ms 1 with annotations by her, of the Pharmacy ordering/dispensing/recording systems;
- A list of items said to have been deleted from the Registrant's own PMR (Patient Medication Record) at the Pharmacy;
- A summary table prepared by Ms 1.

22. In making the application Mr Thomas submitted that the additional information was rebuttal evidence in response to the Registrant's positive defence to particular 4, recently received in the Registrant's witness statement. Whilst the burden remained on the Council, inevitably, it was submitted, the Committee would be called upon to evaluate the Registrant's defence and the material in the bundle would assist in that task.

23. With the agreement of both parties, the Committee had been provided with the addendum statement and exhibits ahead of the application being made.

24. The Registrant's representative did not oppose the application.

25. The Committee accepted the advice of the Legal Adviser, which included that the potential admission of further material at this stage was governed by Rules 24 and 18(5), the latter preventing late admission of evidence unless the Committee considered that there were 'exceptional circumstances'.

26. The Committee noted that in his statement the Registrant had offered a positive defence to particular 4. It noted too that this only had been recently received by the Council and that there had then been the Easter break all of which had made it difficult to obtain and provide this evidence earlier.

27. The Committee considered whether the circumstances leading to this application met the test of 'exceptional circumstances'. The Committee considered that they did. It was accepted that the Council was only in receipt of the Registrant's positive defence at a point in time when any rebuttal evidence to be gathered would then have been outside the time limits set in Rule 24.

28. Having considered the statement and exhibits the Committee considered that the material appeared to be directly relevant to the facts to be determined by the Committee. As the material related to the systems that the Registrant would have been required to use in the Pharmacy, the Committee determined that it would not be unfair to the Registrant to admit it. The Committee noted that the application was not opposed.

29. Accordingly for the reasons set out above the Committee determined to accede to the application.

Second Application to admit further evidence

30. The Committee then received an application from Ms Manning-Rees on behalf of the Registrant to have admitted into evidence details of a formal Warning – Document 5 delivered to the Council's witness by the Council's Investigation Committee - the fact of which is in the public domain.

31. In making the application Ms Manning-Rees submitted that the purpose in seeking to have the material admitted into evidence was not to seek to impugn the Council's witness. The Warning was relevant, it was submitted, because it was given in relation to staffing matters at Jhoots, at the relevant time, albeit at different branches than the one at which the Registrant had worked. It was submitted that staffing was a contextual factor related to the Registrant's defence in respect of the staffing pressures being faced within the Pharmacy in the relevant timeframe within the allegations.

32. It was submitted that the material could not have been submitted earlier because the Warning had only been delivered on 25 March 2024.

33. The application, given the intended purpose, and in particular which was not intended to impugn the credibility of the Council's witness, was not opposed by Mr Thomas.

34. The Committee received and accepted in full the advice of the Legal Adviser.

35. The Committee recognised that a Warning delivered to the SI of the Pharmacy regarding matters of staffing would be potentially relevant to the matters to be determined by the Committee given the Registrant's defence. The Committee noted that the application, on the basis on which it was being made, was not opposed. The Committee noted that the Warning had only been given on the 25 March 2024

36. Taking into account the above the Committee determined that the material was relevant, and that it would not be unfair to the Council to admit it. The Committee considered that the fact that the Warning had only been given on 25 March 2024 amounted to an 'exceptional circumstance' under Rule 18(5).

37. Accordingly, the Committee acceded to the application.

Third Application to admit further evidence

38. The Committee then received from the Council an application to admit into evidence a further document – Document 6- which was an image of two till receipts for the Pharmacy within the relevant timeframe, the first dated 12 August 2021 and the second dated 2 September 2021. Both receipts contained a description of the items paid for which read 'Prescriptions Private'.

39. It was submitted that this further documentation also was of the nature of rebuttal evidence to the Registrant's positive defence to particular 4. The application was not opposed. The Committee received further legal advice, which it accepted in full.

40. Applying the same reasoning as above the Committee considered that the tests of relevance, fairness and exceptional circumstances were met. Accordingly, the Committee acceded to the application.

Fourth Application to admit further evidence

41. Later, during the giving of evidence at the Facts stage Mr Thomas took the SI to a document supplied as part of her addendum bundle. It was observed that this document, and others within the same exhibit, were overly redacted, so that whilst patient names, properly, were redacted, the quantities dispensed, unnecessarily were also redacted which prevented a comparison being made between those quantities allegedly dispensed by the Registrant to himself and those to other patients at the Pharmacy.

42. Mr Thomas made an application to have a different version of the document – Document 7 - admitted into evidence with the unnecessary redactions removed to allow a direct comparison. This was not opposed. The Committee received and accepted legal advice.

43. Because the less redacted document was the better evidence, and because the Committee considered that the tests of fairness, relevance and exceptional circumstances were met, for the same reasons as given above, the Committee admitted the document into evidence.

Registrant's response to Particulars of allegation

44. The Registrant admitted particulars 1, 2 and 3 and denied particulars 4 and 5.

45. In the light of the above, and by the application of Rule 31(6) of the Rules, the Chair found that the admitted factual particulars were proved.

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

Background

47. The Registrant was employed by Jhoots Pharmacy from September 2020 and worked as the Pharmacy Manager in one of their branches, Raddlebarn, in Selly Oak in Birmingham ('the Pharmacy').

48. PRIVATE

49. In May 2022 whilst the Registrant was away on holiday a locum pharmacist working at the branch raised some concerns internally about the accuracy and completeness of entries in

the Controlled Drug register and the lack of annotations on methadone scripts - FP10MDAs, ('blue scripts'). A Superintendent Pharmacist (SI) for Jhoots Healthcare Limited, commenced an internal investigation, which later was taken over by another SI, Ms Shah ('the SI'). Jhoots suspended the Registrant from his employment whilst conducting their investigation. Before that investigation had been completed the Registrant resigned in June 2022. Later during the investigation it became apparent that there had been a number of entries made on the Registrant's Patient Medication Record (PMR) which were marked as private prescriptions.

50. A range of concerns were reported to the police by Jhoots. It is agreed between the parties that the Registrant was arrested and interviewed by the police in October 2022 and that the Registrant agreed to undertake a drug test in police custody and tested negative for cocaine and opiates. In April 2023, the police indicated to the Council they would not be progressing criminal charges against the Registrant in relation to the matters in this case.

51. On 29 June 2022 the SI reported concerns to the Council. An internal investigation had revealed that many hundreds of entries that should have appeared in the CD register had not been entered, while other entries were incorrect. The purpose of a CD register is to maintain a detailed and accurate record of receipt, administration and disposal of controlled drugs. This is to ensure that any shortfalls/missing CDs or errors in dispensing can be quickly identified and rectified.

52. Other concerns came to light regarding the management of CDs– in particular that methadone scripts were not being properly annotated. Methadone scripts often are dispensed in instalments so that whilst a script will specify a total volume, that might comprise a number of doses dispensed to the patient over a period of days, or a number of weeks. To keep proper track of what had been dispensed and when (and to record if and when doses have been missed because the patient did not turn up) the script must be annotated to record each dose dispensed or missed. If the blue scripts are not annotated, or not annotated accurately then patients are at risk of being given incorrect doses of methadone, a CD and a drug of abuse. When more than three days doses have been missed, it is incumbent of the pharmacist to inform the patient's prescriber and that prescription will be cancelled. Once the doses are complete, or the script cancelled because a number of doses have been missed, the script is then sent to the pricing bureau.

53. Prompted by patient complaints to the Pharmacy, the internal investigation revealed that in addition to missing annotations, incorrect doses of methadone had been given to patients on a number of occasions.

54. All these matters are the subject of allegations 1,2 and 3 and admitted by the Registrant.

55. Subsequently, at the beginning of August 2022, a further concern was identified in relation to private prescription records in the Pharmacy. It was found that the Registrant had made a number of entries to his own PMR and coded them as private prescriptions.

56. Private prescriptions are relatively rare in most community pharmacies: these are written and dispensed outside of NHS arrangements. The patient pays a treating clinician who may

authorise a prescription. When such prescriptions are dispensed the patient pays for the medications, along with a dispensing fee determined by the pharmacy. Private prescriptions are required to be recorded as such in pharmacy records on the relevant patient's PMR, so thereby effectively creating for the pharmacy a Private Prescription register.

57. Hard copies of private prescriptions have to be retained for a statutory period of a minimum of 2 years. Such scripts are dispensed outside of the NHS arrangements and so are not sent to the pricing bureau. A search of the Pharmacy as part of the internal investigation found no private prescriptions for any patient during the periods in question.

58. The Registrant provided in his statement a positive defence to the allegation that he had improperly dispensed drugs to himself - recorded as a private prescriptions in his PMR - without a prescription. The Pharmacy records show a number of instances of items being entered on the Registrant's PMR between March 2021 and November 2021. The records also show that on one date, 12 August 2021 -items marked as private prescriptions were deleted from the Registrant's PMR.

59. The Registrant's defence is that he had entered items onto his own PMR only for the purpose of ordering those items into the Pharmacy for other patients, and that he had devised this method of doing so because, he says, the company's method was overly time-consuming. As part of this defence the Registrant states, and accepts, that there were in fact no private prescriptions issued to him. He denies that he dispensed to himself any of the medications listed in Schedule A and denies removing them from the Pharmacy.

Kuzmin Warning

60. When considering each particular of allegation, the Committee bore in mind that the burden of proof rests on the GPhC 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.

61. At the closing of the Council's case, on behalf of the Registrant, Ms Manning-Rees stated, when invited to open its defence case, that the Registrant had elected not to give oral evidence.

62. The Chair then delivered the first part of what is called 'the Kuzmin Warning' to the Registrant in terms as follows: 'I am informing you that it is open to the Committee, in appropriate circumstances, if you do not give evidence, that this Committee may draw an inference from this. This is your opportunity for you to tell this Committee if you believe you have a reasonable explanation for not giving evidence'.

63. This warning delivered was in line with the legal advice received on this matter which was as follows:

‘It is open to the Committee to draw an inference from Mr Cave’s decision not to give evidence, if it is satisfied of the following:

1. A *prima facie* case to answer has been established,
2. Mr Cave has been given appropriate notice - this was not given to Mr Cave in the Notice of Hearing but you gave notice to him yesterday during the hearing,
3. Mr Cave has been given an appropriate warning - you gave this to Mr Cave yesterday during the hearing,
4. Mr Cave has been given an opportunity to explain why it would not be reasonable for him to give evidence - you gave this to Mr Cave yesterday during the hearing,
5. If you find that Mr Cave has no reasonable explanation why it would not be reasonable for him to give evidence - you found this to be the case yesterday,
6. Mr Cave has been given an opportunity to give evidence after you found that he had no reasonable explanation - you gave this opportunity to Mr Cave yesterday,
7. There are no other circumstances in Mr Cave’s case which would make it unfair to draw such an inference’.

64. The Committee adjourned to allow the Registrant to discuss this with his representative after which Ms Manning-Rees stated that the Registrant was not going to give evidence. His explanation was that this was because “he was unable to give answers over and above or beyond those already given in his written statement”. In addition, whilst not going as far as to say that he was unwell or had a health condition preventing him from giving evidence, the Registrant position was not “mentally able” to do so.

65. Having obtained legal advice, which it accepted, the Committee retired to consider this explanation. The Committee concluded that it did not amount to a reasonable explanation for not giving evidence. This was because firstly whilst he said he was unable to answer questions beyond what he had put in his written statement, the Registrant did not know what questions, if any, he might be asked either under cross-examination, or by the Committee: therefore, there remained a possibility that he could answer questions. Secondly, the assertion that he was not “mentally able” to answer questions was not further explained nor corroborated by any form of medical of other supporting evidence. The Committee decided that this was not therefore a reasonable explanation.

66. Having announced this finding, the Chair then adjourned again to provide a further opportunity for the Registrant to consult his representative to explore whether, in light of the Committee’s decision, he now wished to give evidence. Ms Manning- Rees then confirmed that the Registrant would not be giving evidence.

67. The Committee then heard submissions on the Facts from both parties.

68. It should be noted that the Committee had requested, given the elapse of time between the initial and reconvened hearing, and the complexity of the evidence, that submissions at this stage should be in writing. Both advocates agreed to do so. This was appreciated by the Committee which found those written submissions of considerable assistance. The parties then made oral submissions based on those written submissions.

69. In addition to receiving the usual legal advice at this stage of proceedings, given that there was an allegation of dishonesty, the Committee received the following further legal advice:

70. 'It is not in dispute that the test set out by the Supreme Court in the case of *Ivey v Genting Casinos,* as set out in detail in Mr Thomas's written submissions, applies to professional discipline cases.

71. In summary, the test is: you must first ascertain subjectively the actual state of Mr Cave's knowledge or belief as to the facts and then go on to consider whether Mr Cave's conduct was honest or dishonest applying the objective standard of ordinary decent people'.

Decisions on Facts

Particular 4

Between 19 March 2021 to 18 November 2021 on up to 23 occasions dispensed a mixture of POMs, including Schedule 3 and 5 drugs within Schedule A, to yourself in circumstances where there was no prescription against which to dispense the POMs.

72. The Committee accepted in full the legal advice it had received.

73. The Committee took into account all the documentary evidence before it in the bundles from both parties, which included the Registrant's written statement, the written and oral evidence from the Council's witness, and the submissions of both parties, including that it was accepted that the Registrant has no previous regulatory history.

74. The Committee began by examining what the Registrant had said in his statement about the particular reasons why he had, he said, resorted to placing items on his own PMR coded as private prescriptions. The key explanation given by the Registrant in his written statement is as follows

> *'When I started at the pharmacy, the dispenser showed me on the first day, how I was meant to order stock into the pharmacy, and this involved a long and time-consuming process, where I would have to check on the system with each of 4 suppliers what types of each medication they had and the price of each. Once I had carried out this task to determine which was the cheapest, unless a prescription specified a particular brand, I would then be able to place an order with the appropriate supplier for that particular medication'.*

75. The Committee reminded itself of the evidence – detailed below- which it had heard from Council's witness, Ms 1, the SI at Jhoots who had taken over and completed the internal investigation into what had occurred in the Registrant's branch. That investigation had examined the issues to do with the incorrect and missing entries in the CD register and the lack of and/or incorrect annotation to the prescriptions for methadone. The SI had also been the person who had examined the Registrant's PMR and had found the entries he had made and deleted. She had then undertaken various analyses of what had been ordered into the Pharmacy.

76. The Committee heard extended oral evidence from the SI about the ordering systems at the Pharmacy at the material times. The Committee had found some of this evidence difficult to follow. In part this was because the witness was seeking to explain a computer system's dynamic functioning using only her oral explanations accompanied by the screenshots she had made during the course of her internal investigation. The witness also was seeking to address questions from the Council and the Committee about how the system functioned in some detail and whether it contained the limitations claimed by the Registrant in his lately received defence to this particular of allegation.

77. In part the Committee found some difficulty arising from the witness's mode of answering questions in which she frequently caveated her answers in imprecise terms. This necessitated often many further questions of clarification in order for her intended and specific meaning to be made apparent. Nevertheless, ultimately the Committee achieved the clarity it required from the witness who did make clear, including under cross-examination, the limits to her knowledge or the limits to the internal investigation carried out by her and others at Jhoots.

78. The SI readily made some concessions when cross-examined, for example that there was no direct evidence that the Registrant had either consumed or removed any of the items listed on his PMR marked as private prescriptions from the Pharmacy. She was not cross examined or challenged about the operation and function of Pharmacy ordering system.

79. Having heard this evidence about how the medication ordering system in the Pharmacy operated, and having asked numerous questions of clarification, the Committee found the SI's evidence to be reliable, consistent and the Committee accepted her evidence on this topic.

80. The Committee established from the witness's evidence that there were three routes via which items/medications could be properly and legitimately ordered into the Pharmacy by the Registrant. The Committee also had the benefit of the SI's addendum statement and exhibited to that a document titled 'Your Onboarding programme; Branch Ordering – Stock & Resources.

81. The first route – which for the purposes of this determination we, the Committee, call Route 1 - was by entering the items required by a particular patient's prescription onto that patient's PMR. By completing and processing such an entry the items sought automatically would be loaded onto the 'Order Pad' feature of the prescription processing and medication ordering system, (called 'ProScript').

82. The second route - which for the purposes of this determination we, the Committee, call Route 2 - was by entering items, in anticipation of future requirements generally or for particular patients, directly onto the 'Order Pad'. The Committee had heard from the SI that it was frequently and regularly the case that in a branch at the day's end there are prescriptions not yet processed, i.e. not yet entered individually onto that patient's PMR, meaning that the necessary medication would not therefore be on order via that route. So, in order to ensure medication would be available if the patient was due to come in the next day to collect it, at the day's end branch staff would go through these as yet unprocessed

prescriptions and if it was thought that any required medications were not in stock, then they would enter the required items manually, directly onto the 'Order pad'.

83. Then, periodically, typically daily, or according to the Registrant's written statement, twice daily, all the items on the 'Order Pad' then would be transmitted electronically to various suppliers. The orders for medications were sent automatically to whichever supplier offered, at any given time. the best price, this having been determined centrally within Jhoots. The SI was adamant that there was no requirement for the branch pharmacist to seek to identify which supplier offered the medication at the best price. The SI in her addendum statement at paragraph 8 stated:

> '*Our order pad does not allow brand choice, it may say (TEVA brand) but automatically switches to the cheapest price from Head Office.*

84. The SI explained that there was also a third route -which for the purposes of this determination we the Committee call Route 3 - which was to email internally to seek to order in items which, for whatever reason, could not be obtained via the usual suppliers or were not permitted within the system. The SI stated that the Registrant had used this method on occasion, for example;

> *' Mr Cave has sent an email to stock orders with our head office to obtain the specific brand on 02 September 2021'.*

85. This was corroborated by various emails dated for example 2 September 2021, 26 August 2021, seen by the Committee in the SI's Addendum witness statement.

86. The Committee noted that this evidence as to how the ordering systems worked was corroborated by the following at page 7 of the document referred to above

> *'At Jhoots, we have a software in place that runs in the background with Proscript called LEXON SPYDER. This is designed in a way that the vast majority of items will go directly onto the Lexon order pad. Once you have checked the order before sending, you can Press F10 to transmit the order that is on the Lexon page. The way this SPYDER software works is that even though you are sending the order from the Lexon tab, it will still send the items to their pre designated suppliers that have been determined by the group buyer e.g. AAH, ALLIANCE, LEXON, PHOENIX. If an item is not available through the pre-designated supplier, then the software will automatically try to send it via one of the other wholesalers. If it is still unavailable, then that line will stay on your order pad with a status message attached to it as to why it was not transmitted. You may need to email wholesalers directly to obtain the product or contact Lexon as it may be a special/special obtain item'.*

87. The Committee further heard evidence from the SI who described the training that the Registrant had undergone, and the records of that training, whilst at Jhoots. This included a record of the Registrant having signed that he had read the required Jhoots Standard Operating Procedures (SOPs) by October 2020.

88. The Committee was taken to a certificate listing several elements of training and with a completion date of 29 September 2021. The SI explained that when the Registrant joined Jhoots all the training was paper based. This was replaced by an electronic system, and because the Registrant had already completed all the training, he was required to sign off on this once more -in October 2021. The Committee noted that the training document referred to above had what appeared to be a date on the first page 21/22.

89. Whilst this document appears to be dated '21/22', the year after the Registrant had started with the company and been inducted, the Committee noted that there was no evidence, including in the Registrant's statement, that there had been any change to the ordering systems across that period. The SI had also stated in her oral evidence that this system had been in place across the whole of the time of her employment, which was 18 years.

90. The Committee noted that it was not clear from the Registrant's statement whether the method of ordering which he says he was instructed in by a member of staff at the Pharmacy branch, which required a time-consuming comparison of prices offered by suppliers before an order is made, was within the system described above, or another method altogether lying outside it. It seemed to the Committee that the Registrant might be referring to the Route 2 method of placing items directly onto the Order pad.

91. From the evidence before it, the Committee was satisfied that the Registrant knew about and had used 'Route 1' and knew about and had used 'Route 3'. The Committee by inference concluded that it was highly improbable that he did also know about and use 'Route 2'.

92. In reaching that conclusion the Committee noted that the time-consuming alternative system the Registrant refers to in his statement above, is not described by him in any detail. There is only a straight assertion that there was such an alternative system required to be used by him. The Committee noted that the SI denied any such alternative system existed and had confirmed that Route 2 did not require any form of price comparison exercise.

93. The Committee noted from his statement that the Registrant did feel able to raise and escalate issues:

> *'I did speak to HR, around May 2021, to raise the fact that none of the counter staff were trained to dispense and the difficulties this was causing and to also make them aware of the challenges I was experiencing with these same staff not carrying out the tasks they were allocated or working to the required standard'.*

94. That being so the Committee found that it was not credible that he had not raised with head office, his line manager, the SI, or any colleagues the difficulties he claimed that the time-consuming price comparison ordering system was causing him.

95. The Committee accepted the evidence of the SI about how the Pharmacy ordering system functioned. The SI was cross-examined on this point. However, when it was put to her that the Registrant had been shown another method of ordering by a member of staff at the Pharmacy when he joined Jhoots, she restated and firmly maintained that there was no such

alternative system, and that the system that was in place, Route 2, did not function in the way the Registrant claimed.

96. The Committee next analysed and examined closely the Registrant's explanation in his written statement regarding how he was using his PMR 'work around' and when and why.

97. The Registrant states at paragraph 55 of his statement:

> *'On the occasions that I processed these medications on my PMR, I did this in order to quickly order stock to the pharmacy.'*

98. The Registrant states at paragraph 58 of his statement:

> *'Therefore, on a number of occasions, particularly when patients would mention to me that they wanted a specific brand of medication for instance, and I had no time, I utilised this work around as a way to ensure that the pharmacy would have the right stock, but without me having to spend a lot of time, that I did not have, doing this manually'.*

99. The Registrant states at paragraph 60 of his statement:

> *'I resorted to using my PMA* [sic] *to quickly and efficiently order stock that was specifically required for the pharmacy, mainly to fulfil specific patient requests for a particular brand, as I found this a much quicker and more efficient way to order stock, compared to the usual method, which I had been shown when I started at the pharmacy'.*

100. The Committee examined closely the list of 23 items that appeared on his PMR (and which had not been deleted). It noted that the greater majority of these were in fact for generic medications and not for 'a particular brand'. Of the 23 items on his PMR (which are listed at Schedule A to the allegation) it is within the knowledge of the Committee that only 6 of these are in fact brands; , Avomine, the GSF Syrup, Orilstat, Zydol, Macrobid, and the Free Style Lancets. Therefore, the Committee concluded that what the Registrant had stated at paragraph 60 was demonstrably wrong when he claimed that he resorted to ordering via his PMR '*mainly to fulfil specific patient requests for a particular brand…'*

101. The Committee also considered that there is a fundamental illogicality in this part of the Registrant's explanation. If the Registrant had been minded to order a brand for a patient who had been prescribed a generic formulation, given, as he says, that he was able to order and dispense to a patient a branded medication by placing it on his PMR, why would he not have simply done so instead by using the patient's own PMR? The Registrant's statement is silent on this. The Committee concluded that this explanation for his actions was not credible and therefore it was highly improbable that this was the reason he was entering items onto his PMR marked as private prescriptions.

102. The Committee next examined the evidence of the two till receipts showing that on two occasions during the period in question items recorded as being private prescriptions had been put through the till in the Pharmacy. The first showed a date of 12 August 2021, and timed at 18.27, which is a date which the documentary evidence shows that items had been

deleted from the Registrant's PMR; and the second on 2 September 2021, timed at 18.13, a date on which items were added to the Registrant's PMR.

103. The Committee noted that those receipts do not name the person who put the items through the till, nor for whom the items were intended. However, the Committee noted the Responsible Pharmacist (RP) log provided in evidence titled 'Attendance Register'. It noted that the Registrant was the RP on both of these days. It noted further the time which the Registrant had recorded as being logged in and had logged himself out as RP. He logged out as RP on 12 August 2021 at 18.27 and logged out as RP on 2 September 2021 at 18.13.

104. The Committee noted also that the till receipt dated 2 September 2021 was in the sum of £70.00. It noted also that when added up the total of the figures in the 'Cost' column of the list of the items listed as being found on entered on the Registrant's PMR on 2 September 2021 was £69.99. The Committee had noted the SI's oral evidence that the figures in this Cost column represent the amount that would be charged to a patient dispensed those items under a private prescription.

105. The Committee noted also that this item had been put through the till after the Pharmacy's scheduled 6pm closing time and on a day when the Registrant was RP and had logged himself out as RP just a minute prior to the till transaction. The Committee noted that in his statement the Registrant himself stated that he regularly came into the Pharmacy at 8am and stayed late, up to 7pm. The Committee noted that no private prescriptions had been found in the Registrant's name. It noted too the Registrant's written admission in his statement accepting that there were no private prescriptions. It noted that the SI's evidence that there were no private prescriptions for any patient during this period.

106. Taking all of this into account the Committee concluded that on the balance of probabilities the evidence indicated that it had been the Registrant who had put this sum through the till that day and had done so to pay for items listed on his PMR.

107. The Committee did not have before it in the documentary evidence detail about the cost information for the items entered on the Registrant's PMR and then deleted on 12 August 2021. However, it noted that the SI's oral evidence on this matter. When asked by the Committee about this she said:

> *'Those items, when I put it through one of our PMRs, you know the quantity, you know the prices of them amounted to around £300.00'.*

108. For the same reasons as above, taking all the evidence into account, the Committee concluded that, on the balance of probabilities, it had been the Registrant who had put this sum through the till that day also and had done so to pay for items that he had been put on but had then deleted from his PMR.

109. Having rejected the Registrant's explanations of his actions as to why he had placed items on his own PMR and marked them as private prescriptions, the Committee turned then to see if the Council had proved the particular of allegation, specifically whether the Council had proved that the Registrant had 'dispensed' to himself.

110. Whist giving her evidence the SI was asked first by the Committee, and then in re-examination by the Case Presenter, what she understood by the term 'dispensed' and at what point a medication ceased simply being a medication in the Pharmacy and came to be 'dispensed'. The Committee wished to explore this issue given that Particular 4 uses, and might be said to hinge upon, this term: it does not say simply that he removed medication from the Pharmacy.

111. The witness struggled somewhat with being precise and consistent in her initial answers on this matter. In response to the Committee's questions she agreed that labelling the item ready to be given out to a patient was a required step before an item could be considered to have been dispensed. However, in answer to further questions later under re-examination, the SI stated that an item will have been 'dispensed' if it appeared on a PMR because if a pharmacy was asked or challenged (for example as part of an NHS query or investigation) about whether an item in fact had been dispensed, then the PMR record would be considered to be an authoritative record of that.

112. The Committee accepted this unchallenged evidence. The Committee noted that the SI had been somewhat equivocal in her answers to the Committee's questions. This was understandable. The question as put appeared to be not one that the SI had previously had reason to think about in those terms. However, the Committee noted that when questioned in re-examination, after reflection, the SI was clear and firm in her subsequent answers in stating that the placing of items of medication on a PMR is sufficient to be regarded as it having been dispensed.

113. Having found proved that the Registrant had placed a number of items onto his PMR on 2 September 2021 and paid for them, and deleted items from his PMR on 12 August 2021 but yet had paid for those, the Committee concluded that on the balance of probabilities the Registrant had dispensed to himself all the other remaining items entered onto his PMR as 'private prescriptions'.

114. Accordingly, the Committee found particular 4 proved.

115. For the avoidance of any doubt, although the Committee delivered to the Registrant the 'Kuzmin warning' that it may draw an interference from the Registrant's decision not to give oral evidence at this stage of proceedings, in the event the Committee made its finding of fact in respect of this particular without drawing or relying upon any such inference.

This particular is found proved.

Particular 5

. Your actions in paragraph 4 above were dishonest in that:

5.1. You knew there was no valid prescription issued against which medicines could be dispensed to you;

And/or,

5.2. You knew that you were not entitled to remove these medicines as they were not prescribed for you.

116. The Committee accepted the advice of the legal adviser.

117. It began its deliberations by recognising that the Registrant himself had admitted the factual element of 5.1, namely that there was in fact no valid prescription against which items on his PMR marked as private prescriptions could have been dispensed to himself.

118. The Committee moved on then, in respect of particular 5.1, and applied the first, subjective, test required for determining dishonesty. It asked itself what had been the Registrant's knowledge and belief as to the facts when he had placed each of these items marked as private prescriptions on his PMR.

119. Reminding itself of its findings at particular 4 above and in line with those findings the Committee concluded that having assessed all the evidence before it and having taken into account the submissions made by each party, on the balance of probabilities, the Registrant's knowledge, belief at the time that he placed those items on his PMR was not to order them for other patients but instead to dispense those items to himself.

120. The Committee then moved on to apply the second limb of the test. It asked itself if ordinary decent people would consider that to be dishonest.

121. The Committee determined that ordinary decent people would consider it to be dishonest because the Registrant was obtaining items to which he was not entitled, including a mixture of Prescription Only Medications (POMs), some of which are controlled drugs.

122. The Committee then turned to consider particular 5.2. Here the Committee noted that the Registrant did not accept and had not admitted that he had removed any medicines, although he had admitted he had no private prescription for any of the items on his PMR marked as private prescriptions.

123. In line with its findings at particular 4, the Committee considered it was reasonable for it to infer that having found that he was dispensing to himself, he had done so with the intention of removing the items and, on the balance or probabilities, concluded that he had in fact removed those items. The Committee therefore found that at the time of placing the items on his PMR, his belief as to the facts was that he knew they had not been prescribed for him, and that he was placing them on his PMR with the intention of removing them.

124. The Committee then went onto apply the second limb of the test for dishonesty and considered how ordinary decent people would regard that belief as to the facts. The Committee concluded that ordinary decent people would regard it as dishonest because the Registrant was removing the items, including POMs some of which were controlled drugs, which had not been prescribed to him.

125. Accordingly, the Committee found particular 5.2 proved

126. Having found both particulars 5.1 and 5.2 proved, the Committee found particular 5 proved.

127. For the avoidance of any doubt, although the Committee delivered to the Registrant the 'Kuzmin warning' that it may draw an interference from the Registrant's decision not to give oral evidence at this stage of proceedings, in the event the Committee made its finding of fact in respect of this particular without drawing or relying upon any such inference.

This particular is found proved.

Misconduct and Impairment

128. Having found all the particulars of 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.

129. The Committee took account of the guidance given to the meaning of 'fitness to practise' in the Council's publication *"Good decision-making"* (Revised March 2024). Paragraph 2.12 reads:

> *"A pharmacy professional is 'fit to practise' when they have the skills, knowledge, character, behaviour and health needed to work as a pharmacist…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."*

130. The Committee took into account the submissions made by both parties.

131. Mr Thomas on behalf of the Council submitted that the Registrant's conduct amounted to misconduct and that this was the case in respect of all the particulars of allegation and submitted that the Registrant had breached a number of the Standards for Pharmacy Professional (May 2017). He submitted that the Registrant had shown some insight as regards those particulars which he had admitted. However, because he had not been working in pharmacy since being suspended from practise, he had not been able to demonstrate if and how he had remediated this conduct and therefore, it was submitted, the Registrant's fitness to practise was impaired in respect of those matters. As to the findings of dishonesty: this was a matter which the Registrant had denied and had had little or no opportunity to display insight. It was submitted that dishonesty, being an attitudinal failing involving matters of character is, notably more difficult to remediate.

132. It was submitted that the failures especially in respect of patient safety and the finding of dishonesty would shock the public. Mr Thomas submitted that the Registrant's fitness to practise was currently impaired.

133. In the submissions on behalf of the Registrant by Ms Manning-Rees, she commenced by relaying that the Registrant had understood and had accepted the Committee's findings on the Facts. It was accepted that the Registrant's actions amounted to misconduct. It was submitted that in his statement and reflective account the Registrant had demonstrated some insight, and had also demonstrated a measure of insight in making admissions to particulars 1,2 and 3. However it was accepted by the Registrant that the level of insight demonstrated likely would not be considered by the Committee to be sufficient to avoid a finding of impairment and so such a finding was anticipated on personal and public interest grounds.

134. The Committee accepted in full the advice of the legal adviser, including on the case of Sawati – v – GMC [2022] EWHC 283 (Admin) which considered the situation where a Registrant denies allegations which then are subsequently found proved. In assessing the Registrant's insight, the Committee took this and other matters into account.

Decision on misconduct

135. When considering whether the particulars found proved amounted to misconduct the Committee took into account the '*Good Decision making guidance'* Fitness to Practice Hearings and Outcomes Guidance revised March 2024 ('the Guidance').

136. 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 as set out below.

137. 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).

138. The Committee looked first at those particulars that the Registrant had admitted, namely particulars 1,2 & 3.

139. In respect of the allegations 1, 2, 3, the Committee finds a breach of the following Standards:

- Standard 8: *'Pharmacy professionals must speak up when things go wrong'* in that the Registrant failed to be '*open and honest when things go wrong'*. The Standard makes clear the following: *'At the heart of this standard is the requirement to be candid with the person concerned and with colleagues and employers. This is usually called the 'duty of candour' – which means being honest when things go wrong'.* The Registrant failed to speak up to alert others, in particular his employer and the Superintendent when he knew he had failed for some months to keep an accurate and up-to date CD register.

- Standard 5 *'Pharmacy professionals must use their professional judgement'* because in failing to dispense the correct doses of methadone, the Registrant failed to *'make the care of the person their first concern and act in their best interests'.*

- Standard 2: *'Pharmacy professionals must work in partnership with others'* in that by failing to properly annotate methadone prescriptions the Registrant did not *'make and use records of the care provided'* upon which other healthcare professionals would rely for the treatment of the patient and in so doing failed to *'make sure there is continuity of care for the person concerned'.*

140. In respect of particulars of allegation 4 and 5 and the Committee finds a breach of the following Standards:

- Standard 2: *'Pharmacy professionals must work in partnership with others'* in that by improperly using his own PMR to dispense items to himself without a valid prescription the Registrant did not properly *'make and use records of the care provided'* upon which other healthcare professionals would rely for the treatment of the patient and in so doing failed to *'make sure there is continuity of care for the person concerned'.*

- Standard 6: *'Pharmacy Professionals must behave in a professional manner'* which require that they *'are trustworthy and act with honesty and integrity'* in that the Registrant was dishonestly using his own PMR to dispense to himself items, including controlled drugs, when he knew that he had no valid prescription for them.

- Standard 9: *'Pharmacy professionals must demonstrate leadership'* which requires that pharmacy professionals *' do not abuse their position..'* and should *'assess the risks in the care that they provide and do everything they can to keep these risks as low as possible'*

141. In respect of particular 1, the Registrant's conduct resulted in several hundred either missing, incomplete or incorrect entries to the Pharmacy's CD register. The requirement for an accurate CD register is a statutory requirement designed to ensure the effective control and facilitate safe custody of CDs. This ensures accountability and helps prevent misuse and diversion of CDs. It is a key, central, non-negotiable, non-discretionary responsibility of a pharmacist and sits at the heart of the trust placed in the profession by the public. The Committee concluded that the extent and duration of this conduct, and the failure by the Registrant to alert others to this failure, was sufficiently serious to amount to misconduct.

142. In respect of particulars 2 and 3, the Registrant's conduct included dispensing incorrect doses of methadone to a number of patients, and failing to properly annotate FP10 MDAs prescription forms , including for methadone, with the doses given to patients and/or missed doses. A core duty of a pharmacist is to ensure the safety of patients by ensuring that patients receive the correct medication in the appropriate dosage, particularly so for prescription only medications, and especially so for CDs. The failure to properly annotate the doses administered, and/or missed doses directly and adversely impacted the care of patients and thereby created a significant risk to patient safety. The Committee found that in relation to this conduct the Registrant had failed to provide safe and effective care. The Committee found that this conduct in respect of each of particulars 2 and 3 of the allegation was sufficiently serious to amount to misconduct.

143. In respect of particulars 4 and 5, the Committee considered that the Registrant's conduct in dispensing POMs to himself, including Schedule 3 and 5 CDs, without a valid prescription to be sufficiently serious to amount to misconduct. This is because this conduct constituted a breach of trust placed in him as pharmacist in his role of custodian of CDs by both the public generally and his employers specifically. The Committee has found that the Registrant's conduct in dispensing to himself and removing items without a valid prescription was dishonest. Any factual finding of dishonesty arising from the behaviour of a pharmacist must amount to misconduct, being as it is, a clear breach of a fundamental tenet of the profession.

144. The Committee considered that this misconduct by the Registrant squarely met the description in the case of Nandi V GMC in that it fell so far short of what is required that members of the public, and in particular members of the profession, would find it 'deplorable'.

145. Taking all of the above into account the Committee therefore determined that the facts found proved meant that the Registrant's conduct was sufficiently serious in respect of each of the particulars found provided to amount to misconduct.

146. Accordingly, the Committee concluded that the ground of misconduct is established.

147. The Committee therefore went on to consider whether the Registrant's fitness to practise is impaired.

Decision on Impairment

148. Guidance on fitness to practise is provided in Rule 5(1) of the Rules, which states that the Committee must have regard to the criteria specified in paragraph (2) when deciding if the requirements as to fitness to practise are met in relation to a registrant.

149. Rule 5(2) provides that in relation to evidence about the conduct or behaviour of the registrant which might cast doubt on whether the requirements 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 on.

150. The Committee concluded that all of the above elements are engaged. The Committee considered that:

- the Registrant's failure to administer the correct doses of methadone put those patients at actual risk of harm.
- each and every one of the facts found proved had brought the reputation of the pharmacy profession into disrepute.
- the failure to maintain an accurate and up- to- date controlled drugs register, and dispensing to himself CDs without a valid prescription, both to be breaches of the fundamental principle of the profession that pharmacy professionals be trusted custodians of medicines and especially controlled drugs.
- the failure to ensure the integrity of his PMR, and the failure to ensure that patient's methadone prescriptions were properly annotated, breached a fundamental principle of the profession that pharmacy professionals ensure the correct maintenance of statutory pharmacy and patient care records
- dishonestly removing numerous items of prescription only medications, including CDs to which he was not entitled shows that the integrity of the Registrant can no longer be relied upon.

151. The Committee considered whether and the extent to which the explanations and expressions of remorse in the Registrant's written statement and reflective account amount to insight into, what happened, why it happened and the impact of what happened.

152. The Committee reminded itself that the Registrant had chosen not to give evidence the Committee had not had an opportunity to ask the Registrant questions to test his explanations, his insight and expressions of remorse. However, despite that limitation the Committee judged that as regards particulars 1,2 & 3 the Registrant had demonstrated in his written statement and reflective account that he had understood what had happened, and had given some explanation, although not a full explanation, of why he had behaved as he had.

153. The Committee considered that he had also recognised the impact that his conduct likely would have upon the safety of patients by not giving out the correct doses of methadone, and the general impact of his conduct would have had on the public's confidence in the profession. However, the Committee considered that the Registrant had not adequately explored in his statement or reflective account why it was that he had allowed his conduct to fall to so very seriously short of the standards required

of any pharmacist when he failed to maintain an accurate CD register and to annotate the FP10MDAsand ensure that correct does of methadone were given out , and why he had wholly failed to bring any of this to the attention of employers, line manager or colleagues.

154. The Committee considered that the Registrant had shown some insight, in the abstract sense, into what impact a finding of dishonesty would have on the public's confidence in the profession. However, by virtue of the fact that the Registrant had, as he was perfectly entitled to, denied the dishonesty allegation, and because he had not given oral evidence at this stage of proceedings, it was the case that the Registrant could not and had not shown yet any insight into the Committee's finding of dishonesty and equally had not yet had time to even begin to remediate that misconduct.

155. For the reasons given above, the Committee determined that much of the Registrant's conduct was not readily remediable because, both in the persistent failure to raise concerns about his failures in respect of the CD register and properly annotating methadone prescriptions, and in his dishonesty, the conduct found proved contained attitudinal failings.

156. Further, the Committee considered that the Registrant had not in fact remediated his misconduct and therefore there remained a risk of repetition, particularly if the circumstances at his workplace and in his private life which he indicated led up to his misconduct were to be repeated.

157. The Committee determined that the unremediated failings as regards patient safety and the risk of repetition mean that the Registrant's fitness to practise is impaired on the ground of public protection.

158. The Committee judged that the extent to which standards had been breached, the nature and extent of the misconduct, and in particular the finding of dishonesty mean that a finding of impairment is required, irrespective of whether that conduct had in fact been remediated. The Committee determined that a finding of impairment is necessary to mark the seriousness of what has occurred. Such a finding is required to maintain public confidence in the profession and uphold professional standards.

Decision on Outcome

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

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

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

162. The Committee took into account the submissions made by Mr Thomas on behalf of the Council, in particular that:
- The Registrant has no previous fitness to practise determinations with the Council;
- that the Registrant has been under an interim order of suspension since 26th of October 2022, which was extended twice by the High Court with the consent of the Registrant, which consequentially has meant he has not been able to demonstrate remediation through his practise as a pharmacist;
- Removal from the register is reserved for the most serious conduct when that conduct was fundamentally incompatible with being a registered professional;
- There are two sets of serious concerns which the Committee might consider possibly are linked in respect of attitudinal failings;
- Particulars of allegation 1 to 3 reflect conduct which the Council concedes was neither malicious nor for any personal gain but however are reflective of matters that were so far out of control and for a significant period of time as to constitute a serious lapse of professional judgement;
- The Registrant failed to flag up these matters neither did he remove himself from his responsibilities in the Pharmacy;
- The Committee's findings have indicated that that the duty of candour has been engaged in respect of particulars 1 to 3 and considers that this is not simply a performance issue;
- There are matters to do with patient safety here which are very significant and have not been remediated and which taken alone would call for some restriction on the Registrant's ability to practise;
- In respect of allegations 4 and 5 it is submitted that this conduct is "on the cusp" and are close to the top end of seriousness and is a course of conduct which occurred on six dates so constitutes a course of conduct;

163. Mr Thomas went onto to submit that:
- The Committee should consider where that dishonesty lies on the scale of dishonesty and it might be that the Committee concludes it is less serious than some instances that bring registrants before fitness to practise committees;

- The Registrant’s conduct was a breach of the trust placed in the Registrant both by society and his employers;
- There was no evidence of onward supply;
- The record which he affected in respect of particulars 4 and 5 was only his own PMR and so the Committee may feel that this does not necessarily fit within the example given in the guidance that might elevate it in the scale, namely the ‘falsifying of patient records’;
- This was not dishonesty directed towards a patient or the treatment of a patient.

164. Mr Thomas submitted that the Council had indicated in its skeleton argument at the outset of proceedings that the appropriate outcome would be a period of suspension of 12 months. It was submitted that the Council does not depart from that but recognises that the Committee might feel that having examined the totality of the misconduct across the allegations, and in light of the evidence that it heard from the SI, that it might conclude that the Registrant’s conduct did approach the top end of seriousness.

165. In summary it was submitted that the least that is required in order to protect the public and uphold public confidence in professional standards is a lengthy suspension. However, the committee may feel that it needs to consider whether things had gone so badly wrong that only an outcome of removal would be sufficient to meet the expectations of the public, uphold professional standards and restore public confidence in the profession.

166. Ms Manning-Rees on behalf of the Registrant submitted that:

- The Registrant accepted that it was likely that he would be removed from the register;
- He recognised the seriousness of the allegations and the findings made against him;
- The Committee could consider that there was an option other than removal. That whilst the registrant had stated that he had no current intention to return to the practise of pharmacy, if he were to be given the opportunity to reflect then a period of suspension of say 12 months would give him the opportunity to properly absorb the Committee's findings. Such a period of suspension with a review would then give him the opportunity to reflect and give a better informed view as to whether he wished to continue to practise within the profession;
- PRIVATE
- PRIVATE
- PRIVATE

- it was recognised that this was all personal mitigation but nevertheless it was submitted it should be taken into account.

167. It was also submitted also that the following were mitigating factors that should be taken into account:
    - The Registrant was young and junior in his career and perhaps too junior for the role that he was employed to fill at the Pharmacy;
    - the mechanism of his dishonesty was unsophisticated and therefore quite identifiable;
    - that whilst he had used his PMR improperly this was not for the whole of the period that he had been employed at the Pharmacy;
    - the Registrant previously was of good character;
    - the Registrant has engaged in these proceedings and has complied with all the requirements of the process;
    - the Registrant did not contest the interim order of suspension placed upon him;
    - that he holds the profession in high regard and is devastated to have brought it into disrepute;
    - that the documents submitted by the defence included a positive character reference which commends the Registrant for his kindness, patience and compassion which are important characteristics and qualities in healthcare;
    - that the SI in evidence had said that she did not believe that the Registrant was a bad person.

168. Finally, Ms Manning Rees submitted that removal was not the only option and a suspension order would both protect the public and would be an outcome that was an entirely reasonable one for this Committee to make.

169. The Committee received and accepted in full the advice of the Legal Adviser.

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

171. The Committee identified the following mitigating factors:

    - the Committee has identified that there was some insight displayed by the Registrant in relation to the admitted particulars 1 to 3 and it is recognised that the Registrant had undertaken some CPD in relation to propriety and ethics;
    - That the time of the Registrant's employment at Jhoots coincided with the COVID pandemic which served to place community pharmacy services under particularly increased stress and demands;

- that from January 2021 the Registrant whilst having other staff in the pharmacy with him did not have any qualified support staff;
- that there were a number of personal circumstances and family matters occurring from 2021 that may have impacted upon his ability to focus upon his professional responsibilities;
- that there have been some health matters referred to which became more acute during the period of his employment;
- that in respect of particulars 1 to 3 there was nothing malicious in his failures.

172. The Committee identified the following aggravating features:

- There were two distinct courses of conduct, the first in respect of particulars of allegation 4 and 5 which extended from March 2021 to November 2021, and the second course of conduct in relation to particulars of allegation 1 to 3 which extended from February 2022 to June 2022: neither of these were isolated failures, they were repeated;
- in respect of the entries made on his PMR and the removal of items of medication, this conduct was both premeditated and deliberate;
- in respect of the Registrant's persistent and prolonged failure to ensure that the CD register was up to date this too was deliberate;
- the Registrant had failed to escalate at any point in time within the company or elsewhere the concerns arising and issues that he had created in respect of the ongoing failure to keep an accurate and up-to-date CD register or the failure to properly annotate methadone prescriptions;
- that the Registrant even when suspended from his employment and knowing he was under investigation for the conduct giving rise to particulars of allegation 1-3, failed to alert his employers to his conduct that gave rise to particulars 4 and 5;
- that the Registrant's actions, in particular the failure to give out the correct doses of methadone, had the effect of placing what are, by definition, a vulnerable group of patients at significant risk of actual harm;
- that in respect of allegations 4 and 5 the Registrant had abused the trust placed in him both by the public and by his employers;
- that the Registrant had abused his position and his knowledge of pharmacy systems in devising his method of obtaining and removing items of medication which included numerous controlled drugs;
- the adverse impact on his fellow professionals both in necessitating that they establish and correct what he had failed to do in respect of annotating the methadone prescriptions and also in seeking to identify and rectify the errors in the CD register
- the scale of the incorrect and or missed entries in the CD register, which were in the order of 700 over a period of several months, which meant that despite the efforts of fellow professionals, the proper entries could not be made and the register properly reconciled;

- the number and extent of the breaches of the Standards which the Committee had identified, being breaches of Standards 2,5,6,8 and 9.

173. The Committee then considered, in respect of the findings for particulars 4 and 5, where the Registrant's conduct sat on the scale of dishonesty.

174. In examining where on the scale of dishonesty the Registrant's conduct sat the Committee considered that the following features of his conduct and circumstances of his conduct were relevant.

    - this dishonesty had taken place at work in a pharmacy setting;
    - that it was both a breach of the trust placed in him by the public and his employers;
    - that it was an abuse of the position of a pharmacist in deploying what he knew about pharmacy systems in order to obtain, dispense to himself and remove items of medication which he knew that he was not entitled to;
    - that those medications included a number of controlled drugs;
    - that this had been repeated on six occasions across a span of approximately 8 months.

175. The Committee noted the submissions made by Mr Thomas that the falsification of records in this case in relation to the Registrant's dishonesty was confined to his own PMR, and not the records of other patients. However, the Committee concluded that the deliberate falsification of any patient record, including his own, was conduct that breached a fundamental principle of the profession that pharmacists not only be the custodians of medications but that they ensure the integrity of records in respect of those medications.

176. Taking this all into account the Committee concluded that the Registrant's dishonesty in all the circumstances was toward the top end of the scale.

177. With all that in mind the Committee then turned to consider which of the possible outcomes open to it was the proportionate and appropriate outcome in this case.

178. The Committee reminded itself that it had concluded in the previous stage of proceedings that there remained a real risk of repetition of the conduct described in particulars of allegation 1-3 due to the Registrant's deficiencies of insight and lack of remediation. And that because of this risk of repetition there remained a real risk of future harm to patients if the Registrant were to be permitted to practise without restriction.

179. That being so the Committee concluded that neither taking no action nor issuing a warning could be the appropriate outcome in this case because neither of those outcomes would serve to protect the public from a potential repetition of the Registrant's conduct.

180. The Committee considered the next outcome on the list of options which was an order of conditions. However, the Committee did not consider that such an outcome

could be appropriate in the circumstances of this case. Even in respect of particulars 1-3 the Committee could not conceive of an order of conditions that would meet the failures identified. It would not be practicable that there would be a simple condition for example that the Registrant maintain an up to date and accurate CD register given that that was already a non-negotiable, statutory requirement. Nor, given the attitudinal failures which had been identified in failing to escalate these concerns and observe the duty of candour which is laid upon all healthcare professionals, as well as the attitudinal failures in respect of the finding of dishonesty which always raises a question about a registrant's character, did the Committee consider that an order conditions could be an appropriate outcome in this case.

181. The Committee next considered an order of suspension. The Committee noted the Council's guidance which indicates that suspension may be appropriate where:

> "*The Committee considers that a warning or conditions are insufficient to deal with any risk to patient safety or to protect the public, or would undermine public confidence. It may be required when necessary to highlight to the profession and to the public that the conduct of the registrant is unacceptable and unbefitting a member of the pharmacy profession. Also, when public confidence in the profession demands no lesser sanction."*

182. The Committee recognised that such an order during its duration would serve to protect the public from any repetition of the Registrant's conduct.

183. The Committee then considered whether or not an order of suspension of up to 12 months could be sufficient to address the public interest concerns in this case. To assist in that consideration the Committee reflected upon what it would have considered to be the appropriate outcome in this case if the only particulars of allegations before it were numbers 1-3.

184. The Committee concluded that given the nature, extent and seriousness of these failures alone it would have imposed a lengthy order of suspension to address those public interest considerations. It then asked itself if there had been only allegations 4 and 5 what it would have considered to be the appropriate outcome in this case. And once again, given the aggravating factors that it had identified in relation to that aspect of the Registrant's conduct, and where it sat on the scale of dishonesty, again it would have imposed, nothing less than a lengthy order of suspension.

185. Taking that into account and taking into account the totality of the Registrant's conduct and the impact it likely would have on the public's confidence in the profession, and the extent that it has brought the profession's reputation into disrepute, and the undermining effect it could have on professional standards, the Committee concluded that the appropriate and proportionate outcome in this case must be removal from the register.

186. The Committee reached this conclusion because it had determined that no other outcome, including an order of suspension for a period of 12 months would be

sufficient to retore public confidence, repair the damage to the reputation of the profession and uphold professional standards.

187. The Committee recognises the impact such an outcome will have upon the Registrant's reputation and may have on his personal circumstances, and has taken that fully into account. However, weighing those considerations fully in the balance the Committee finds that his interests are outweighed by the public interest in these matters.

188. The Committee therefore directs that the Registrar remove the Registrant's entry from the register.

Interim Order

189. As required by Article 56(10) of the Pharmacy Order, having made a finding of impairment and having directed that the Registrant's entry on the register be removed, the Committee hereby revokes the Order of Suspension currently in effect in respect of the Registrant.

Decision on Interim Measure

190. Having handed down its decision on outcome and having resolved to remove the Registrant's name from the register the Committee heard an application from Mr Thomas on behalf of the Council inviting the Committee to impose an interim measure order of suspension forthwith because the Committee's substantive decision will not take effect until 28 days after notice of this decision has been sent, or until any appeal has been finally disposed of.

191. Mr Thomas submitted that without such an interim measure there was a risk presented by the Registrant's unremediated performance issues. These gave rise to the risk of repetition of his conduct and a risk of patient harm. It was submitted that if there was no order this risk would not be managed.

192. Further there was a finding by the Committee that the integrity of the Registrant could no longer be relied upon therefore an interim measure of suspension was otherwise in the public interest in order manage the risk of any further undermining of public confidence in the profession and professional standards.

193. Mr Manning-Rees on behalf of the registrant did not oppose the application.

194. The Committee received and accepted in full the advice of legal adviser.

195. The Committee accepted the submissions made on behalf of the Council and determined that an order of suspension was required as an interim measure as being necessary to protect member of the public and was otherwise also in the public interest.

196. This concludes the determination.

Appendix 1 : the original allegations as contained with the Notice of Hearing

You, a registered Pharmacist whilst working as the Responsible Pharmacist at Jhoots Pharmacy, 65 Raddlebarn Road, Selly Oak, Birmingham, West Midlands, B29 6HQ,

1. On one or more occasions between 1 February 2022 and 30 June 2022 you for one or more patients;

1.1 failed to dispense the correct measure or titration of methadone

1.2 Failed to endorse the FP10MDA with the amount of methadone dispensed

1.3 Dispensed controlled drugs in circumstances where there was no prescription against which the controlled drug could be dispensed

1.4 Failed to maintain accurate and/or up to date records in the Controlled Drugs Register

1.5 Between 19 March 2021 to 18 November 2021 you on one or more occasions dispensed POMs to yourself in circumstance where there was no prescription against which to dispense the POMs.

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

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