General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote videolink hearing

11-13 November 2024

Registrant name:	James Nicholls
Registration number:	5015480
Part of the register:	Pharmacy Technician
Type of Case:	Caution and Misconduct
Committee Members:	Neville Sorab (Chair) Esosa Osakue (Registrant member) Andrew Popat CBE (Lay member)
Committee Secretary:	Chelsea Smith
Registrant:	Not present and not represented
General Pharmaceutical Council:	Represented by Fiona Martin, Case Presenter
Facts proved:	1, 2, 4 (in its entirety), 5.1 and 7
Facts proved by admission:	None
Facts not proved:	3, 5.2, 6 (in its entirety)
Fitness to practise:	Impaired
Outcome:	Removal
Interim measures:	Interim suspension Order

This decision including any finding of facts, impairment and sanction is an appealable decision under *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010*. Therefore, this decision will not take effect until 11 December 2024 or, if an appeal is lodged, once that appeal has been concluded. However, the interim suspension set out in the decision take/s effect immediately and will lapse when the decision takes effect or once any appeal is concluded.

Particulars of Allegation (as amended)

You, a pharmacy technician,

During the course of your employment at the London Clinic ("the pharmacy")

1. *On the 26 April 2023, you inaccurately added 56 tablets of dihydrocodeine 30 mg tablets ("the medication") to patient A's patient medication record.*
2. *On the 26 April 2023, you inaccurately added 56 tablets of the medication to patient B's patient medication record.*
3. *On the 6 April 2023 you inaccurately added 56 tablets of the medication to patient C's medical record.*
4. *Your actions at paragraphs 1-3 above, were dishonest in that:*
    - 4.1. *knew that the patients had not been prescribed the medication;*
    - 4.2. *intended the entries to suggest the patients had been prescribed the medication;*
    - 4.3. *used the log in details of your colleague, to record the entries at paragraphs 1 and 2;*
    - 4.4. *made entries at 1 and/or 2 and/or 3 above in order to remove the medication for yourself and conceal your actions.*
5. *On three occasions between the 17 April 2023 and 22 April 2023:*
    - 5.1. *you submitted controlled drug requests for ICU ward, NF1 ward and L2 ward*
    - 5.2. *your actions in 5.1 above were undertaken in order to obtain the medication for your own use or benefit.*
6. *Your actions at paragraph 5 were dishonest and lacked integrity in that you:*
    - 6.1. *knew that the medication was not required at the following wards: ICU ward, NF1 ward, and L2 ward;*

6.2. used the log in details of your colleague, to record the entries at paragraph 5.

7. On the 14 July 2023 you received a police conditional caution from the Metropolitan Police for the theft of 112 dihydrocodeine tablets, contrary to section 1(1) and 7 of the Theft Act 1968.

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

a. Misconduct;

b. Caution

Documentation

Document 1- GPhC hearing bundle

Document 2- GPhC skeleton argument

Document 3- Amended particulars of allegation

Document 4- Proof of Service bundle

Document 5- Proceeding in absence bundle

Document 6- Proof of email serving 9 day

Witnesses

Mr 1

Ms 2

Ms 3

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 2024.

5. A Principal Hearing has up to three stages:

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

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

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

6. There were three observers on 11 November 2024 and one observer on 12 November 2024. All were newly appointed statutory committee members. The observers did not take any part in the hearing.

Service of Notice of Hearing

7. The Committee has seen a letter dated 10 October 2024 from the Council headed "Notice of Principal 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.

Proceeding in the absence of the Registrant

8. The Registrant was not in attendance at this hearing, nor was he represented.

9. On behalf of the Council, Ms Martin requested the Committee to proceed in the absence of the Registrant under Rule 25 on the basis that:

   a. The Committee has found good service of Notice, which set out that the Committee may proceed with the hearing in the Registrant's absence.

   b. The Registrant is aware of today's proceedings. The Registrant has voluntarily absented himself from this Interim Order Application Hearing. In an email to the Council dated 18 October 2024, the Registrant set out: "*Just to confirm as I have previously that I have not held a pharmacy role ever since the incident and do not plan to ever return. I have admitted to yourselves and the police to what I have done so no I am not planning to go to the hearing.*" Similar emails were sent by the Registrant to the Council on 9 November 2023 and 16 July 2024.

   c. There was no information to suggest an adjournment would result in the Registrant's attendance in future.

   d. There are alleged public protection concerns in this case and a public interest in the case being considered expeditiously.

10. The Committee determined to proceed in the absence of the Registrant for the reasons set out by Ms Martin in paragraph 9 above.

Application for hearing to be held partly in private

11. Ms Martin made an application for health matters, which will be referred to during the hearing, to be heard in private pursuant to Rule 39(3). This is to ensure the rights of the Registrant are balanced with the public interest for proceedings to be held in public.

12. The Committee decided that pursuant to Rule 39(3), any matters relating to the Registrant's health will be heard in private. The Registrant's privacy, in this regard, outweighs the public interest in holding that part of the hearing in public.

First application to amend the particulars of allegation

13. The Committee heard an application under Rule 41 from Ms Martin to amend allegations 1 with the following additions in underline:

> *On the 26 April 2023, you inaccurately added 56 tablets of dihydrocodeine 30 mg tablets ("the medication") to patient A's patient medication record.*

14. The proposed amendment to allegation 1 is to include a description of the tablets which are referred to currently as "*the medication*". Without the description it is unclear which tablets or medication the Council is referring to.

15. Ms Martin also applied to add allegation 3 to the Particulars:

> *"3. On the 6 April 2023 you inaccurately added 56 tablets of the medication to patient C's medical record."*

16. Ms Martin submitted that the proposed amendment and addition to the Particulars did not impact on the scope or nature of the allegations. The additional allegation is simply a further example of the same conduct. Furthermore, the evidence in support of the new allegation 3 was included in the Rule 14 bundle served on the Registrant. Therefore, the Registrant is aware of the full scope of the evidence against him.

17. The Registrant was not present to make submissions on the application.

18. The Committee was of the view that the amendment to allegation 1 clarifies the allegations and would not prejudice the fairness of these proceedings. The Committee was of the view that the addition of allegation 3 is an example of the same conduct set out at allegation 1 and 2. The Committee was of the view that the addition of allegation 3 would not prejudice the fairness of these proceedings as the evidence to support this addition has been served to the Registrant and he was on notice of the amendment (having received the Council's skeleton argument on 1 November 2024) and evidence supporting the amendment (in Council's bundle). Consequently, the Committee allow the amendment to allegation 1 and the addition of allegation 3.

Preliminary Matter – Consideration of allegations that relate to more than one category of impairment

19. Rule 28 sets out:

> *"(1) As regards any fitness to practise allegation before the Committee, if—*
>
> *(a) the particulars of the allegation in the Notice of Hearing relate to more than one category of impairment of fitness to practise; and*
>
> *(b) those particulars include a conviction or caution,*
>
> *the chair must ensure (by adapting the procedure for the hearing, where necessary) that at the principal hearing, the Committee makes its findings of facts in relation to the allegations that do not relate to the conviction or caution before it hears and makes its findings of fact in relation to the conviction or caution.*
>
> *(2) In the circumstances set out in paragraph (1), the chair must also ensure (by adapting the procedure for the hearing, where necessary), that the Committee only makes its decision as regards impairment of fitness to practise once it has made its finding of fact in relation to all the allegations set out in the Notice of Hearing."*

20. In order to comply with Rule 28, the Committee will take account of the witness statements from the Registrant's ex-colleagues at the pharmacy and the Registrant's own account in order to determine allegations 1 to 5 before going on to consider the signed police caution supporting allegation 6.

Second application to amend the particulars of allegation

21. Following the reading out of the allegations, the Committee heard a further application under Rule 41 from Ms Martin to amend allegations 4.3 with the following additions in underline:

> *Your actions at paragraphs 1-3 above, were dishonest in that used the log in details of your colleague, to record the entries at paragraphs 1 and 2 <u>and 3</u>.*

22. Ms Martin submitted that the proposed addition to allegation 4.3 does not impact on the scope or nature of the allegations. The additional allegation is simply a further example of the same conduct. Furthermore, the evidence in support of the new allegation 4.3 was included in the Rule 14 bundle served on the Registrant. Therefore, the Registrant is aware of the full scope of the evidence against him.

23. The Registrant was not present to make submissions on the application.

24. The Committee was of the view that the addition to allegation 4.3 would prejudice the fairness of these proceedings as, although the evidence to support this addition has been served to the Registrant, he was not on notice of the amendment as it was made on the morning of 11 November 2024 and the Registrant was not present to be aware of it or make any submissions concerning the amendment to allegation 4.3. Consequently, the Committee did not allow the amendment to allegation 4.3.

Third application to amend the particulars of allegation

25. Following the reading out of the allegations, the Committee considered there to be an error in the allegations and considered under Rule 41 to amend allegation 5.2, the stem of allegation 6 and allegation 6.2 with the following addition in underline and removal in strikethrough:

> *5.2 your actions in ~~4.1~~ 5.1 above were undertaken in order to obtain the medication for your own use or benefit.*
>
> *6. Your actions at paragraph ~~4~~ 5 were dishonest and lacked integrity in that you:*
>
> *6.2 used the log in details of your colleague, to record the entries at paragraph ~~4~~ 5.*

26. The Committee considered these to be typographical errors caused by the addition of allegation 3. The amendment to the allegations is not based on any new evidence and was originally in the allegations and correctly reflected previous allegations. However, the addition of allegation 3 resulted in a change of the previous allegations

referred to. Therefore, the Registrant is aware of the full scope of the evidence against him, and there would be no prejudice to the fairness of the proceedings.

27. Ms Martin did not oppose the proposed amendment.

28. The Committee amended allegation 5.2, the stem of allegation 6 and allegation 6.2, for the reasons set out in paragraph 26.

Background

29. On 3 May 2023, the Council received a concern from Mr 1, Head of Pharmacy at the London Clinic ("the Pharmacy") informing the Council that a member of staff had been inaccurately inputting medication on patient medication records and diverting the medication. Discharge prescriptions for two patients dated 26 April 2022 showed they had been prescribed co-codamol and metronidazole. However, the Pharmacy's medicine entry showed that 56 tablets of dihydrocodeine 30mg had also been dispensed for each patient without a prescription. CCTV showed that the Registrant was the person who dispensed these medications, but he was logged in to the pharmacy computer system as a colleague, Ms 3.

30. As part of the internal investigation, the Registrant was interviewed on the 28 April 2023. In this interview he confessed to removing the 112 dihydrocodeine tablets for his own use. The Registrant had previously had his own prescription for these tablets, but it had ended. The Registrant stated that he had only diverted the 112 tablets on 26 April 2022.

31. Further internal investigation uncovered other instances where dihydrocodeine had been issued from the pharmacy system without a prescription. On 6 April 2023, 56 tablets of dihydrocodeine were booked out to Patient C who had a cataract procedure. Dihydrocodeine had not been prescribed to this patient. CCTV showed the Registrant at the computer at the relevant time however Ms 3 (who was not present) was the person whose log in was used to book out the medication.

32. On the 18 April and 21 April 2023, 168 tablets of dihydrocodeine had been booked out to three in-patient wards without corresponding orders from those wards. The

controlled drug registers for the three wards indicated that no supply of this medicine was received.

33. The matter was also referred to the Controlled Drug Liaison Officer at the Metropolitan Police on the 3 May 2023.

34. The Council commenced an investigation into the concern, and witness statements were obtained by the Council.

Evidence

35. The evidence of Mr 1 and Ms 3 was read into the record. Ms 2 attended and gave live evidence.

36. Mr 1 provided the following evidence:

    a. On the evening of 27 April 2023, he was notified by Mr P, operational lead for dispensary and distribution at the Pharmacy, that the Pharmacy cash drawer was unable to be closed down, due to a payment collection missing from the day prior. In order to resolve the issue, Mr 1 reviewed all collected payments for the 26 April and also ran a report to look at patient charges, to identify where the outstanding amount could be from.

    b. On reviewing the patient prescription charging data, it showed an outstanding charge for prescriptions which had been supplied. This was unusual; therefore Mr 1 looked into some patient accounts to try and determine where these charges were from. Mr 1 found that there were two patients who had three charges on their account. Both patients had charges on their account for Metronidazole, Co-codamol 30/500 and Dihydrocodeine. The charges for Metronidazole and Co-codamol totalled 29.29 which had been paid for. Mr 1 spoke to Mr P, who stated that both patients only had 2 items on their discharge prescription which were for Metronidazole and Co-codamol However, there was an outstanding charge of £11 for each patient for dihydrocodeine 56 tablets (112 in total for both patients). Mr P was working a late shift, therefore Mr 1 asked him to carry out a stock check of dihydrocodeine.

c. Mr P confirmed that the stock levels were correct, which meant dihydrocodeine that had been booked out from the pharmacy, had left the pharmacy. It was not clear where this medication had gone as it had not been prescribed to the patients who had an outstanding charge for it.

d. On 28 April 2023 at 11:30 hours, Ms J presented Mr 1 with two discharge prescriptions for Patient A and Patient B. It was clear that neither patient had been prescribed Dihydrocodeine.

e. Mr 1 cross referenced the prescriptions to the Meditech reports for the issue of dihydrocodeine and could see that both were processed by username PH.ZC at 12:04 and 12:06 hours. The username of staff member PH.ZC, is Pharmacy Technician Ms 3. Mr 1 was informed by Ms J that at the time of the transaction, Ms 3 should have been on their lunch break, therefore their duty should be covered by the Registrant.

f. On 28 April 2023, Mr 1 instructed Mr P not to let the Registrant work openly in the dispensary and not let him generate labels for dispensing. Mr 1 did this as something was clearly not correct. At that point Mr 1 had not ascertained who had actually been using the terminal at the relevant time and Mr P was on annual leave on 28 April 2023. Mr P had spoken to Ms J, who had suggested to restrict access to medications whilst CCTV was looked at, as well as login / transaction information.

g. Mr 1 decided to view the CCTV for those relevant times. He attended the security office and requested to view the footage. Mr 1 watched the footage in the presence of a security staff member. When viewing the CCTV, he recalled seeing Ms 3 sat at the computer terminal. She then stood up from the computer terminal just before noon. The Registrant arrived in the dispensary promptly at noon to start his lunch time cover. Ms 3 briefly stayed in the area while the Registrant sat down at the same computer terminal that Ms 3 had been sat at. Ms 3 appeared to be applying hand sanitizer or moisturiser to her hands. Ms 3 then departed the dispensary.

h. The Registrant then proceeded to pick up prescriptions to be dispensed. He appeared to process the prescriptions on the computer, tear off the labels for the items and place in a tray ready to be dispensed. They sat in the tray location for several minutes untouched. As it was lunchtime, there was few staff around, and after a period of time the Registrant picked up the medicines for dispensing. The CCTV does not show the Registrant leave the dispensary with any medication. The transactions to decrement the stock level and the taking of the medicine were not concurrent. Mr 1 believes that the Registrant had an understanding of stock check frequency and exploited that to remove stock to "correct" the stock level at a different time from when the dispensing occurred.

i. From the transaction data that Mr 1 have reviewed, he is not aware of a way of identifying which computer a transaction is completed on, however there are only a few computers in the dispensary. The time stamps on the CCTV match the time on the computer system. The CCTV showed there was only one person labelling at the time of the transaction, which was the Registrant.

j. Mr 1 then decided to discuss this incident with the medicines safety officer, Ms 2, and we agreed to meet with the Registrant at the next available time, which was around 3pm on 28 April 2023. At that meeting, when presented with the findings, the Registrant appeared confused and momentarily struck with nervousness, claiming he did not understand how the transaction could have appeared on Ms 3's account. Mr 1 went through the process of explaining that the patients had not paid or collected the dihydrocodeine medications but yet the stock levels had remained accurate which suggested the medication had left the pharmacy. Ms 3 explained that when the medications were credited to the patients account, this would create a discrepancy as payment was not taken for medication that has left the pharmacy. The conversation with the Registrant did not seem to be progressing, as he seemed so confused, so Mr 1 asked to adjourn the meeting to discuss it with Ms 2 around next steps.

k. The Registrant left the room for approximately 2 minutes at the point of adjournment and then voluntarily returned. He then admitted that he had taken the medication, 112 dihydrocodeine tablets. [PRIVATE] Mr 1 asked if this was the

only occasion that he had taken medication from the dispensary for his own use and the Registrant said yes. Mr 1 asked him to write and sign a statement of the events of 26 April 2023 surrounding the two prescriptions.

l. Mr 1 then spoke to the HR team and the CDAO (Controlled Drugs Accountable Officer) about the findings. The Registrant was then instructed to leave the premises and that there would be a follow up from HR after the bank holiday weekend.

m. Mr 1 sent an email to HR and the CDAO at 17:30 hours that day and then to the MET police CDLO (Controlled Drugs Liaison Officer) and CDAO to explain the situation.

n. Mr 1 also asked Mr P to run a further report into the utilisation and issuing of Dihydrocodeine to patients to confirm if this had been an isolated incident, or if there were any unusual transactions of the drug, or instances where there is outstanding balance on the patients' accounts.

o. Mr 1 received an email from Mr P on 2 May 2023 at 11:12 hours to inform him that there were potentially additional instances involving Dihydrocodeine that may have occurred. Mr 1 requested a further report into all dispensing of the Registrant since he had been working in the dispensary, which was approximately 8-10 weeks. Ms 2 and Mr P looked into this. Mr 1 not aware of the full details of their findings but was updated that further potential concerns had been found.

37. Ms 2 provided the following evidence:

a. The Registrant started working at the Pharmacy in November 2022. He is a "bank employee", in that he was not a permanent member of staff. He was on a zero-hour contract and was paid weekly. The Registrant was a permanent staff member about 3 years ago but left due to personal reasons. He worked 2-3 days a week as a Pharmacy Assistant. He would hold the role of dispenser to cover in the Pharmacy, during lunchtimes which is typically expected of staff. As well as dispensing, the Registrant was responsible for administrative work and was involved with stock control, including ordering and pricing.

b. Ms 2 did not work directly with the Registrant but would normally see him once a week or so. During the period that he was not working at the Pharmacy, his registration (allowing him to act as a Pharmacy Technician) lapsed and so when he started back with us in 2022, he was working as an assistant until he registered in March 2023.

c. Ms 2 generally worked in an office on the third floor but was in and around the hospital and wards frequently. Ms 2 covered in the Pharmacy normally 3-5 hours a week.

d. The Pharmacy is on the ground floor, then the floors above this (up to 8) are all surgical wards, ICU and imaging. The Pharmacy offices are in the basement, this is where the Registrant would operate, as well as in the Pharmacy.

e. The Pharmacy is roughly an L shape. It consists of a bench, with computers and shelving on the main arm of the L. At the right angle is the controlled drugs room and then the other arm of the L is taken up by fridges and desks. In the Pharmacy there is a hatch for outpatients and a separate hatch for nurses and staff. In the Pharmacy at lunchtime there are normally 4 or 5 people rostered in the Pharmacy dispensary. The Pharmacy mainly deals with inpatients. There is also a steady stream of outpatients, normally around 10-15 a day.

f. In the Pharmacy, dihydrocodeine is on the shelf with the regular prescription medication so all Pharmacy staff can access it. The area for higher schedule drugs is in a separate room in more secure cupboards that require pin-code entry. The dihydrocodeine is roughly in the middle of the shelving but closer to the end of the room and the hatches, rather than the controlled drug room. It used to be just below waist level and was particularly obscured by the desk, so we have moved it higher up the shelf it was on so that it is more in view for the CCTV.

g. Dihydrocodeine is typically dispensed to treat post-operative pain. It is a schedule 5 controlled drug (class B) because of the potential for abuse. The schedules are a way of categorising controlled drugs, schedule 5 being the least restricted and schedule 1 being the most. Schedule 5 means that it is under tighter controls than most medication and is prescription only but is not subject to the same legal

restrictions that higher schedule drugs are. Usually, a patient's prescription for this medication is for a course for 3-10 days in our patient group but is often advised to only take when/if needed. Normally you take 1-2 tablets up to 4 times a day. There are 28 tablets in a pack, most patients do not require a second pack on discharge. The Pharmacy goes through a lot of dihydrocodeine, on average 1000 tablets monthly. Dihydrocodeine is about 1p per tablet at cost, but the prescription is sold for £11 for a pack, however it is also the same charge for 2 or more packs.

h. The Pharmacy has recently changed its payment collection system. Previously patients' accounts were charged with the cost of their prescriptions, and they were billed afterwards. Since 11 April 2023 we take payments in real time when patients come to collect medicines from us.

i. The higher schedule-controlled drugs within the Pharmacy are stored separately in the CD (controlled drugs) room and are subject to a 3 way check as dispensed, by keeping a running balance in the paper register and on the dispensing system. There is a separate monthly check and a quarterly audit. This process is described in full in our local Standard Operating Procedures. Dihydrocodeine is not subject to these additional checks, but is classed as higher risk, compared with regular prescription only medicines and the physical balance is checked against the dispensing system. This drug is checked weekly. Other stock on the shelves is checked monthly. The Registrant was often involved in these checks.

j. At the end of day on Wednesday 26 April 2023, a balance check was carried out and discrepancies were found, in that there were outstanding payments that did not appear to have been taken. A comparison is made between the number of prescriptions dispensed, against the number of payments taken. Since the change of the payment collection service on 11 April 2023, this is a check that is carried out at the end of every day.

k. On Thursday 27 April 2023, the dispensing manager, Mr P, looked at the prescriptions from the day before and found 2 prescriptions of note, for 2 different patients, which he flagged to Mr 1. These prescriptions for both patients

did not include dihydrocodeine, however 56 tablets of dihydrocodeine had been booked out to both patients. A total of 112 tablets.

l. Patient A's prescription prescribed Metronidazole and co-codamol on 26 April 2023 which is shown on the discharge prescription. On the Pharmacy order form, 56 x 30mg dihydrocodeine tablets were booked out to Patient A and their account charged with £11 for these tablets. At the bottom of the Pharmacy order under "history" shows that this transaction was completed on 26 April 2023 at 12:04 by "PH.ZC" which is Pharmacy Technician Ms 3.

m. Patient B was prescribed Metronidazole and Co-Codamol on 26 April 2023 which is shown on the discharge prescription. On the Pharmacy order form, 56 x 30mg Dihydrocodeine tablets were booked out to Patient B and their account charged with £11 for these tablets. At the bottom of the Pharmacy order under "history" shows that this transaction was completed on 26 April 2023 at 12:06 hours by "PH.ZC" which is Pharmacy Technician Ms 3.

n. Having found this discrepancy, a check was carried out on the system and on the shelf stock. The stock levels matched what they should be, confirming that a total of 112 tablets were no longer in the Pharmacy. The Pharmacy checks showed us that those two prescriptions had not been paid for. The system showed that both patients had paid for what had been prescribed to them, in this case for both patients was metronidazole and co-codamol. The dihydrocodeine had not been paid for. It was showing as an outstanding charge on their accounts.

o. The Pharmacy was satisfied that there was no stock discrepancy, so at that time, there was no need to prompt an investigation. It was only due to the recent change in the taking of payments that this incident was discovered.

p. On Friday 28 April 2023, Mr 1 investigated the transactions further, looking into the staff member's account that had authorised both transactions and booking out of the dihydrocodeine. Both transactions had been done within a couple of minutes of each other and according to the log in details on the system, by the same staff member, Ms 3. Mr 1 viewed the CCTV for the relevant date and time. Mr 1 told Ms 2 that he found Ms 3 was on her lunch break on the relevant date

and time. Mr 1 told Ms 2 that CCTV showed Ms 3 leaving the dispensary at 12:00 and then shows another staff member, the Registrant, using the computer at the time the dihydrocodeine was booked out. As mentioned previously, the transactions were time stamped as 12:04 hours and 12:06 hours, at which point Ms 3 was not in the dispensary. Ms 2 has not viewed this CCTV.

q. During the afternoon of Friday 28 April 2023, Mr 1 and Ms 2 approached the Registrant to discuss what had happened. Their discussion with the Registrant was in a private office, with the door closed. This was not a formal meeting. It was a fact-finding discussion to try and help Mr 1 and Ms 2 understand what had happened. The meeting was not recorded. Mr 1 and Ms 2 showed the Registrant evidence of the prescriptions and printouts, showing that dihydrocodeine had been booked out despite not being on the patient's prescriptions. At first, the Registrant said he was confused and did not know anything about this. He asked to go to the bathroom, which was allowed. When he returned a few minutes later, the Registrant admitted to having taken the dihydrocodeine. He said he lied as he was worried about losing his job. [PRIVATE] He said this incident was a one off and was the only time that he had done this. [PRIVATE] Ms 2 does not remember his exact words at the time, but the Registrant said something to the effect of, "*I was lying before, I was fearful of losing my job, I took them*".

r. Ms 2 was aware that due to personal issues, the Registrant has previously declined the assistance of Occupational Health from the Pharmacy. [PRIVATE].

s. At the end of Ms 2 and Mr 1's discussion with the Registrant, the Registrant gave a statement, which he typed on Ms 2's laptop in her presence. Ms 2 can confirm those are the Registrant's words; he was in no way forced or coerced to type the contents of that statement. Ms 2 did not get the Registrant to sign and date this document as she did not think of getting the Registrant to sign and date the document at the time.

t. The incident was then reported to regulators, the General Pharmaceutical Council, the CQC and to the Pharmacy Human Resources team. As the Registrant

was not a permanent member of staff, there was not any kind of formal disciplinary.

u. The Registrant returned to the Pharmacy on Wednesday 3 May 2023 to return his badge and the tablets he had stolen. The tablets had all been removed from their original packaging and were in an unlabelled bottle. It was an amber medicine bottle. Ms 2 counted the tablets and found there to be 84 tablets. Ms 2 did not ask where the other 28 tablets were.

v. When the Registrant attended the clinic on Wednesday 3 May 2023, Ms 2 spoke to him in the presence of Mr 1 and Mr B. Mr B did not know the Registrant at all, therefore was considered to be an impartial neutral party. Mr B said that he would take some notes of the conversation that he was witnessing and then confirmed the contents of the notes with the Registrant at the end of the discussion which the Registrant signed.

w. The other method the Pharmacy found was falsifying drug requisitions to ward stock. Dihydrocodeine is a schedule 5 controlled drug but is treated as a schedule 2 at ward level. This means that it has to be ordered by a nurse working on the ward in a CD order book and a carbon copy is kept of this requisition in the Pharmacy. The medication is booked out and then sent up to the wards via the porter, who tracks the transaction. It is logged into a CD register on the ward and a running balance is kept.

x. Three separate incidents were found, where stock had been booked out to in-patient wards as ward stock on the 18 April 2023 and 21 April 2023. There is no corresponding order in the wards CD registers. Medication booked out totalled 168 x 30mg dihydrocodeine tablets. The ICU CD ward register shows no entries for either 18 April 2023 or 21 April 2023. The NF1 ward also shows no entries for either 18 April 2023 or 21 April 2023. Ward L2 has entries for 18 April 2023, however these have a corresponding Meditech stock management record. There was no record in any of the controlled drug ward registers relating to the Meditech stock management booked out entries.

y. The MediTech stock management/billing software shows 56 x 30mg Dihydrocodeine tablets booked out to two different wards on 18 April 2023. The dihydrocodeine tablets was booked out on both occasions under the log in details of ZC, which is Ms 3.

z. The MediTech stock management/billing software shows the dispensing of tablets of 56 x 30mg Dihydrocodeine tablets for a ward on 21 April 2023. The dihydrocodeine was booked out under the log in details of the Registrant.

aa. On 18 April 2023 and 21 April 2023, neither the Registrant nor Ms 3 were scheduled to be processing the CD (controlled drugs) requests. It is possible that someone could go in and help out with this task, which is not something that would be recorded on the rota.

bb. On 6 April 2023 at 14:25 hours, 56 tablets of dihydrocodeine were booked out to a patient who had had a cataract procedure. That patient had been prescribed Dexamethasone and Chloramphenicol (eye drops). Due to the nature of the procedure, dihydrocodeine would never usually be prescribed to this patient. The system showed that the dihydrocodeine was booked out under log in details for Ms 3. CCTV on this date showed that shortly after Ms 3 left the dispensary, the Registrant can be seen using the computer. The log in details are shown as [PRIVATE], which is Ms 3 however having reviewed the CCTV, she can confirm the Ms 3 was not present in the dispensary at the time they were booked out.

cc. It is important to note that a staff members log in details can only be used on one computer at any one time. Medication can be booked out from any computer, not necessarily just the dispensary computer.

dd. To book out medication as part of a patient's prescription can take under a minute if you are very familiar with the system. Ms 2 considers the Registrant to be familiar with the system, therefore would expect this is something he could complete in under a minute.

ee. CCTV covering the dispensary/Pharmacy is only stored for 30 days so we cannot check the footage for any suspicious transactions, for anything beyond the last 30

days. The CCTV system does not allow any download or sharing of the footage; therefore, it has not been possible to provide any CCTV to the Council. It is only possible to view CCTV on site.

ff. The 112 tablets of dihydrocodeine that the Registrant admits to having stolen, did not and do not belong to him. The Registrant did not have permission to prescribe dihydrocodeine to Patient A or Patient B. The Registrant did not have permission to remove those dihydrocodeine tablets from the Pharmacy. The Registrant did not have permission to remove any dihydrocodeine tablets from the Pharmacy which had not been prescribed to a patient. The Registrant did not have permission to remove any dihydrocodeine tablets from the Pharmacy for his own use. The Registrant used another staff members log in to complete the transactions and in doing so initially hid the transactions to the benefit of himself.

38. Ms 3 provided the following evidence:

a. She is a Pharmacy Technician. She started working at the Pharmacy on 20 September 2022. She has recently stopped working at the Pharmacy. Her role involved dispensing and checking prescriptions, counselling patients, answering the phone, speaking with nurses, and checking stock. Her typical hours of work were 9am-5:30pm with an hour lunch break between 12-1pm. During her lunch hour, another member of staff would cover her position, which was usually timetabled to be the Registrant.

b. As a pharmacy technician, she would predominantly work in the pharmacy. In the pharmacy there are a few desks with computers on them by the back door of the pharmacy. The computer that she always used is near to the back door, facing the wall, with her back to the shelves. The back door is to her left when she sat at the desk. This was the computer used by the dispensers and is right by the phone. It was always a very busy pharmacy, with normally 4 or 5 people in there at a time.

c. During the late part of 2022, she was asked by the management team if she had any suggestions on how to improve the running of the pharmacy. She suggested that the pharmacy could do with another staff member. She was told that we would be getting another member of staff who had previously worked at the

Pharmacy. This new person was the Registrant. He was highly spoken of and knew his way around the Pharmacy and systems, having worked there before. Ms 3 was told that the Registrant had left the Pharmacy in 2022, so would be working part time as a bank employee.

d. The Registrant seemed to settle in well at the clinic. He was friendly and spoke to everyone. Then one day Ms 3 noticed he was not at work and over time she realised that he had not returned to work. Ms 3 assumed the Registrant had got a job elsewhere.

e. Towards the end of May 2023, Ms 3 was called into the office to speak with Mr 1 who asked her if she knew why the Registrant had not been at work. Ms 3 said that she had assumed he had gone to work somewhere else. Mr 1 told Ms 3 that the Registrant had been caught stealing dihydrocodeine and the reason he was speaking to her about it was because the Registrant had been found to have used Ms 3' log in details to steal this medication.

f. Ms 3 was told about an incident on 26 April 2023 when dihydrocodeine was booked out to patients but had not been paid for, which had been done on her log in. Ms 3 lunch break would often be covered by the Registrant. Ms 3 believes that she must have left herself logged on, before going to lunch on this date.

g. Dihydrocodeine is dispensed quite a lot from the Pharmacy, so Ms 3 does not recall how much she booked out on this particular day.

h. Ms 3 does not remember 26 April 2023 specifically, as every day feels the same. However, she takes her lunch break at 12 noon and leaves the pharmacy. She always does this and normally leaves at 12 noon or a couple of minutes after if she is in the middle of something. Ms 3 normally goes to the canteen and sits with friends. This is a short walk away from the Pharmacy, which probably takes about a minute to get there. To get there, Ms 3 leaves the Pharmacy through the back door, heads downstairs, down a corridor and then back up some more stairs.

i. Ms 3 would sometimes leave MediTech (the software we use to manage stock and book out prescriptions etc) open, logged in under her log in as she trusted her colleagues. The pharmacy team is quite small, and all worked well together and everyone got along. Ms 3 never thought twice about leaving herself logged on. If someone in the pharmacy needed to check stock levels for example and they are not logged on to a computer, they might shout across the room, to check with that person, if they can use a colleague's computer to check. If that person is logged on but not around, then they would be logged off and someone would log in under their own name. Ms 3 expected her colleagues would always do the right thing and never dispense under someone else's name. She is certainly not aware of anyone dispensing under someone else's log in, until she was told about what the Registrant had done.

j. The Pharmacy was a very busy place to work and there would be occasions when Ms 3 would step away from her computer, leaving herself logged on before returning. It is not always realistic to log off every time she moved away from her computer and generally, she would be the main person using that same computer all day. Ms 3 never considered that by leaving herself logged on, would provide anyone the opportunity to take advantage of that.

k. Ms 3 has never shared her log in details with anyone and has never agreed for someone else to dispense medication under her log in details. She has not given anyone permission to dispense or book out medication under her name.

l. When Mr 1 spoke to Ms 3 about the Registrant and the incidents involving the dihydrocodeine, Ms 3 was told there had been more than one incident, but she was not provided any specific dates or details. she was told on at least one occasion it involved dihydrocodeine for the wards.

m. Ms 3 was very surprised to be told that the Registrant had been stealing medication. Ms 3 was also very unhappy that it had been done on her log in. Ms 3 immediately felt as though it had made her a suspect and made her look bad. It is very important to Ms 3 how her colleagues perceive her. She considers herself to be very professional.

n. Ms 3 had no idea that the Registrant was experiencing any health issues. He had not disclosed anything to her.

Decision on Facts

39. The allegations in this case are misconduct and caution.

40. In light of Rule 28, the Committee will consider the evidence not in relation to the caution first to determine misconduct, prior to turning its mind to the caution.

41. In reaching its decisions on facts, the Committee considered the documentation listed at the start of this determination, oral evidence and the submissions made by the Council and the Registrant.

42. At the outset, the Committee notes that it found the testimony of Mr 1, Ms 2 and Ms 3 to be clear, coherent and credible. The Committee found no reason not to believe their testimony.

Allegation 1 – On the 26 April 2023, the Registrant inaccurately added 56 tablets of dihydrocodeine 30 mg tablets ("the medication") to Patient A's patient medication record

43. The Committee had sight of the discharge prescription for Patient A dated 26 April 2023 which did not include the medication. The Committee had sight of the pharmacy order dated 26 April 2023 at 12:04pm which dispensed the medication to Patient A, which sets out that it was filed by "PH.ZC". The Committee considers that the medication was dispensed on 26 April 2023 at 12:04pm under the name of Ms 3.

44. The Committee considers that the Registrant dispensed the medication on 26 April 2023 at 12:04pm using Ms 3 account for the following reasons:

a. Ms 3 provides evidence that she takes her lunch break at 12 noon "*or a couple of minutes after if I am in the middle of something.*"

b. Ms 3 provided evidence that the Registrant would often cover her lunch break (which is consistent with the reported CCTV evidence) and that she must have left herself logged in on 26 April 2023, allowing the Registrant access to her

account: "*My lunch break would often be covered by [the Registrant]. I believe I must have left myself logged on, before going to lunch on [26 April 2023].*"

c. Ms 3 provided evidence that she has never shared her log in details with anyone and has never agreed for someone else to dispense medication under her log in.

d. Mr 1 provides a description of the CCTV evidence which sets out that Ms 3 left the dispensary at 12 noon on 26 April 2023 and that the "*time stamps on the CCTV match the time on the computer system. The CCTV showed there was only one person labelling at the time of the transaction, which was [the Registrant]*". Ms 2 explained that the CCTV system does not allow any download or sharing of the footage; therefore regrettably, it has not been possible to provide any CCTV to the Council. It is only possible to view CCTV at the Pharmacy. Although the Committee considers Mr 1's description of CCTV evidence to be hearsay evidence, the Committee considers it to be admissible on the basis that there is independent evidence corroborating what is set out in the hearsay evidence.

45. The Committee had sight of the reflective account attributed to the Registrant, purportedly written on 28 April 2023, in which is it written: "*On the 26/04/23 I booked out 2 separate prescriptions both for Metronidazole and Co-codamol. I also booked out 2 separate lots of 56 x Dihydrocodeine 30mg tablets for each patient. I then proceeded to take the 4 boxes of Dihydrocodeine 30mg.*" The Committee notes that this statement is not dated or signed. However, the Committee considers the reflective account attributed to the Registrant is a fair and accurate account written by the Registrant as it is supported by the following:

a. The Committee has no reason not to believe Ms 2 when she says, in relation the reflective account: "*At the end of our discussion with [the Registrant], he gave a statement, which he typed on my laptop in my presence. I can confirm that those are his words, he was I no way forced or coerced to type the contents of that statement.*" Although the Registrant did not sign and date the document at the time, the reflective account is consistent with other evidence.

b. There is a signed witness statement from the Registrant, competed in the presence of an independent third party on 3 May 2023 in which he says: "*I*

returned to The London Clinic on the 03 May 2023 to hand in the remainder of the 4 boxes of dihydrocodeine I took (approximately 90 tablets). I also handed in my temporary ID card." Although this witness statement is not explicit in that the Registrant inaccurately added the medication to Patient A's medical records, it is indicative of the result of adding the medication to Patient A's medical record.

c. In their evidence, Mr 1 and Ms 2 are consistent in that they both set out that when they confronted the Registrant concerning inaccurately adding the medication to Patient A and Patient B's medical records, the Registrant returned from the bathroom and then admitted having taken the medication.

d. Mr 1's note of 2 May 2023, which is a date close to the allegations, sets out that following his and Ms 2's meeting with the Registrant on 28 April 2023, "*[the Registrant] then returned to the room and then accepted that he was in fact taking the medication.*" Similarly, Ms 2's note of 2 May 2023, which is a date close to the allegations, sets out that following her and Mr 1's meeting with the Registrant on 28 April 2023, "*After a brief break when [the Registrant] asked to go the bathroom, he returned shortly after. He apologised for lying to us and claimed that he had initially not confessed due to fear of losing his job, but that he had taken 112 dihydrocodeine tablets.*" Although these relatively contemporaneous statements are not explicit in that the Registrant inaccurately added the medication to Patient A's medical records, it is indicative of the result of adding the medication to Patient A's medical record.

46. In light of this evidence, the Committee considered that it is more likely than not that on 26 April 2023, the Registrant inaccurately added 56 tablets of the medication to Patient A's patient medication record.

This allegation is found proved.

<u>Allegation 2 – On the 26 April 2023, the Registrant inaccurately added 56 tablets of the medication to Patient B's patient medication record</u>

47. The Committee had sight of the discharge prescription for Patient B dated 26 April 2023 which did not include the medication. The Committee had sight of the pharmacy order dated 26 April 2023 at 12:06pm which dispensed the medication to Patient B, which sets out that it was filed by "PH.ZC". The Committee considers that the medication was dispensed on 26 April 2023 at 12:06pm under the name of Ms 3.

48. The Committee considers that the Registrant dispensed the medication on 26 April 2023 at 12:06pm using Ms 3 account for the reasons set out at paragraph 44 above.

49. The Committee considers the reflective account attributed to the Registrant is a fair and accurate account written by the Registrant for the reasons set out in paragraph 45 above.

50. In light of this evidence, the Committee considered that it is more likely than not that on 26 April 2023, the Registrant inaccurately added 56 tablets of the medication to Patient B's patient medication record.

This allegation is found proved.

Allegation 3 – On the 6 April 2023, the Registrant inaccurately added 56 tablets of the medication to Patient C's patient medical record

51. The Committee had sight of the discharge prescription for Patient C dated 6 April 2023 which did not include the medication. The Committee had sight of the pharmacy order dated 6 April 2023 which dispensed the medication to Patient C, which sets out that it was filed by "PH.ZC". In live evidence, Ms 2 said that she generated the pharmacy order which corresponded to the prescription. The Committee considers that the medication was dispensed on 6 April 2023 under the name of Ms 3.

52. Given that the Committee has not seen the CCTV footage, but only received a summary of the CCTV footage from Ms 2's witness statement, the Committee considers this to be hearsay evidence. Further, the Committee considers this to be hearsay evidence of a matter that is sole and decisive evidence to prove allegation 3. The Committee has noted that Ms 2 explained that the CCTV system does not allow

any download or sharing of the footage; and therefore, it has not been possible to provide any CCTV to the Council. It is only possible to view CCTV at the Pharmacy. Consequently, the Committee has determined that although Ms 2's hearsay evidence is admissible, given the lack of an alternative available to the Committee, little, if any weight, can be given to Ms 2's hearsay evidence.

53. On 3 May 2023, the Registrant signed a witness statement in which he admitted to the diversion and theft of the medication on 26 April 2023, but at no other times.

54. Consequently, the Committee considers that there is insufficient evidence that the Council has reached the threshold to prove this allegation on a balance of probabilities.

This allegation is found not proved.

Allegation 4 – The Registrant's actions at paragraphs 1-3 above, were dishonest in that he:

4.1 knew that the patients had not been prescribed the medication

4.2 intended the entries to suggest the patients had been prescribed the medication

4.3 used the log in details of your colleague, to record the entries at paragraphs 1 and 2

4.4 made entries at 1 and/or 2 and/or 3 above in order to remove the medication for yourself and conceal your actions

55. The case of *Ivey v Genting Casinos (UK) Limited t/a Crockfords [2017] UKSC 67* sets out:

> "*When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must*

be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest."

56. The Committee has found that the Registrant added the medication to the medication records of Patient's A, B and C using the entry details of his colleague, Ms 3. The Committee had sight of the discharge prescriptions for Patients A, B and C, none of which had the medication on it. The Committee considered that only the Registrant, who administered the prescriptions could have added the medication to prescription order. In doing so, the Registrant would have known that Patient's A, B and C had not been prescribed the medication.

57. The Registrant had a motive for making entries for the medication for Patients A, B and C in that [PRIVATE]. He returned some of the medication in relation to Patients A and B, which indicates that he made the entries in order to remove the medication for himself.

58. The Committee considers that the Registrant intended the entries to suggest the patients had been prescribed the medication in order to conceal his actions of removing the medication for himself. The Committee cannot find any other reason for the Registrant's actions.

59. The Committee considers that, subjectively, the Registrant knew what he was doing was dishonest. This is supported by:

    a. the Registrant's statement that the actions of 26 April 2023 (for Patient's A and B) were an attempt to "*divert*" drugs and considered by himself to be "*theft*".

    b. His reported apology to Mr 1 and Ms 2 on 28 April 2023 when confronted with his actions concerning Patient's A and B and that he had not originally confessed for fear of losing his job. The Registrant was aware of the seriousness of his actions.

c. The Registrant had a motive for being dishonesty conducting the actions set out at allegations 1-3 [PRIVATE].

60. The Committee considered it dishonest, objectively, of the Registrant to place on the medical records of patients' medicine that they have not been prescribed, for one's own use. This is not only dishonest, but also dangerous as it creates an inaccurate medical record of the patient which could be relied upon in the future.

61. In light of this evidence, the Committee considered that it is more likely than not that the Registrant's actions in relation to allegations 1-3 were dishonest.

This allegation is found proved.

<u>Allegation 5.1 – On three occasions between the 17 April 2023 and 22 April 2023, the Registrant submitted controlled drug requests for ICU ward, NF1 ward and L2 ward</u>

62. The Committee has seen evidence of the medication of 56 tablets being issued: **a.** twice to two different wards, under the name of Ms 3, on 18 April 2023; and **b.** to ICU, under the name of the Registrant, on 21 April 2023.

63. The Committee has seen evidence that the Registrant was working on 18 April 2023 and 21 April 2023, albeit Ms 2 provides evidence that neither the Registrant nor Ms 3 were scheduled to be processing CD requests on those days; however, it is possible that someone could go and help with this task which is not recorded on the rota.

64. The Committee has not seen any evidence which indicates that the Registrant, in this instance, used the name of Ms 3 to submit CD requests for ICU ward, NF1 ward and L2 ward.

65. In light of the evidence above, the Committee considers that only on 21 April 2023, the Registrant submitted CD requests for ICU, and the allegation is only proved on that basis.

This allegation is found proved.

Allegation 5.2 – On three occasions between the 17 April 2023 and 22 April 2023, the Registrant's actions in 5.1 above were undertaken in order to obtain the medication for his own use or benefit

66. The Committee had sight of the ward Controlled Drug ("CD") registers for the ICU ward, NF1 ward and L2 ward. The ICU CD ward register shows no entries for either 18 April 2023 or 21 April 2023. The NF1 ward also shows no entries for either 18 April 2023 or 21 April 2023. Ward L2 has entries for 18 April 2023, however Ms 2 provides evidence that these have a corresponding Meditech stock management record.

67. The Committee has not seen, nor been presented with, evidence which demonstrates that the Registrant's actions in allegation 5.1 were undertaken in order to obtain the medication for his own use and benefit. Although the modus operandi could be inferred to be similar to that the Registrant used on 26 April 2023, there is no independent evidence suggesting that is what the Registrant did on 18 April 2023 in relation to his actions proved in allegation 5.1. Further, on 3 May 2023, the Registrant signed a witness statement in which he admitted to the diversion and theft of the medication on 26 April 2023, but at no other times.

68. In light of the evidence above, the Committee does not consider that the Registrant's actions, as proved in 5.1, were undertaken in order to obtain the medication for his own use or benefit.

This allegation is found not proved.

Allegation 6 – The Registrant's actions at paragraph 5 were dishonest and lacked integrity in that you:

6.1 knew that the medication was not required at the following wards: ICU ward, NF1 ward, and L2 ward

6.2 used the log in details of your colleague, to record the entries at paragraph 5

69. The Committee has not seen any evidence that the CD request submitted to ICU on 21 April 2023 was not required. Further, the Committee has not seen any evidence that the Registrant used the log in details of his colleague to record the entries raised at allegation 5. Consequently, the Committee considers that the Registrant's actions cannot be classed as dishonest or lacking integrity in relation to allegation 5.

This allegation is found not proved.

Allegation 7 – On the 14 July 2023 you received a police conditional caution from the Metropolitan Police for the theft of 112 dihydrocodeine tablets, contrary to section 1(1) and 7 of the Theft Act 1968

70. The Committee had sight of the Registrant's conditional caution dated 14 July 2023 from the Metropolitan Police for the theft of 112 dihydrocodeine tablets, contrary to section 1(1) and 7 of the Theft Act 1968.

71. Consequently, the Committee finds allegation 7 proved.

This allegation is found proved.

Submissions on Grounds

72. Having found allegations 1, 2, 4, 5.1 and 7 proved, the Committee went on to consider whether allegations 1, 2, 4, 5.1 and 7 amounted to misconduct and a police caution and, if so, whether the Registrant's fitness to practise is currently impaired.

73. In relation to the police caution, on behalf of the Council, Ms Martin submitted that the criminal caution is evidenced within the bundle in the form of the MG14 received from the Metropolitan Police. As the Committee has accepted this evidence as proof of the Registrant's police caution, then this amounts to impairment as per Article 51(1)(j) of the Order.

74. In relation to the misconduct, on behalf of the Council, Ms Martin submitted:

a. The Registrant's conduct as proved, falls far below the standards expected of a registered pharmacy professional. The Registrant's conduct breached the Standards for pharmacy professionals as follows:

    i. Standard 1 – Pharmacy professionals must provide person-centred care;

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

    iii. Standard 5 – Pharmacy professionals must use their professional judgement;

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

    v. Standard 8 – Pharmacy professionals must speak up when they have concerns or when things go wrong; and

    vi. Standard 9 – Pharmacy professionals must demonstrate leadership.

b. [PRIVATE]. This had the potential to put the Registrant's health at risk. Furthermore, the Registrant put his own need to obtain controlled drugs over his duty to use professional judgement (standard 5). This caused him to amend patient prescriptions. He used Ms 3 log in details to make the amendments and dispense the medication. This was not an example of behaving in trustworthy or honest way as required by standard 6.

c. The Registrant failed in his duty to speak up when things went wrong. The Registrant should have been honest with his employer during the relevant period in April to May 2023. Amending patient records alters their medical history (which the patient's would not have known about). This could have impact on those patients' safety or treatment in the future which was not patient centred behaviour (standard 1).

d. The Registrant used his colleagues' log in details when amending patient records and ward orders in order to conceal his actions. This is not only dishonest, but also puts his colleague's professional reputation and job at risk. This is not how a

pharmacy professional leads by example and it is an abuse of the trust that colleagues place in one another. These examples reflect a breach of standards 2, 6, 8 and 9.

e. The Registrant also failed to take full responsibility for his actions and engage with the Council's investigation. Overall, this sets a poor example for his colleagues in breach of standard 9.

f. The Registrant abused his position as a pharmacy professional to access controlled drugs which he removed from his employer without permission. When the Registrant's actions were investigated by colleagues, the Registrant initially denied any involvement or wrongdoing. The Registrant's actions were so serious that they resulted in a criminal caution. This amounts to serious professional misconduct.

g. members of the public and fellow members of the profession would regard the Registrant's use of his colleague's log in details as dishonest. This amounts to a serious professional failing which falls far below the required Standards.

Submissions on Impairment

75. In relation to impairment, on behalf of the Council, Ms Martin submitted:

a. The Registrant received a police caution. No information on how the Registrant has compiled with the caution is available to the Council.

b. [PRIVATE]. The diversion of controlled drugs always poses a potential risk to the public. The Council is yet to receive any evidence from the Registrant to demonstrate that this risk has been remediated and the risk of repetition is low.

c. The Registrant's actions in falsifying patient medication records and attempting to disguise this by using a colleague's computer log in, is an abuse of his position of trust as a pharmacy technician. This has the potential to seriously undermine public confidence in the profession. The Registrant, as a pharmacy professional is considered a gatekeeper of controlled drugs and the alleged conduct strikes at

the core of his duties and further has the potential to bring the profession into disrepute.

d. The Registrant has breached more than one of the fundamental principles of the profession. Standard 5, 6, 8 and 9 of the "Standards for Pharmacy Professionals" are engaged, which provide that the Registrant must use his professional judgement, must behave in a professional manner, must speak up when things go wrong and must demonstrate leadership.

e. The Council submit that the Registrant's integrity can no longer be relied upon as a result of his actions in removing controlled drugs from his employer without permission and in the absence of a legally valid prescription resulting in his police caution. The Registrant knew that he did not have a legally valid reason for removing medicines from the pharmacy yet continued to do so for his own use. This was not a one-off momentary lapse of judgement but a prolonged period of conduct.

f. It is accepted that the Registrant has accepted some of the allegations which shows some insight into his behaviour. However, since the imposition of the conditional caution there has been little to no meaningful engagement from the Registrant with the Council. The only update received by the Council is that the Registrant has no intention of working in pharmacy again.

g. There is insufficient evidence to suggest that the Registrant has demonstrated any insight or attempted to remediate his conduct. [PRIVATE]. There is nothing to assure the Council that should the Registrant find himself with unfettered access to controlled drugs, that the behaviour would not be repeated.

h. Given the serious and criminal nature of the allegations a finding of impairment is needed in order to uphold proper standards, protect the public and maintain public confidence in the profession.

76. The Registrant did not give evidence in relation to misconduct and impairment.

Decision on Grounds

77. 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).

78. The Committee had sight of the criminal caution the Registrant received from the Metropolitan Police, which has been referred to in allegation 7. As the Committee has accepted this evidence as proof of the Registrant's police caution, then this amounts to impairment as per Article 51(1)(j) of the Order.

79. The Committee accepted and applied the following definition of "*misconduct*":

> "*…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 by a practitioner in the particular circumstances*. *The misconduct is qualified in two respects. First, it is qualified by the word 'professional' which links the misconduct to the profession. Secondly, the misconduct is qualified by the word 'serious'. It is not any professional misconduct which will qualify. The professional misconduct must be serious.*"

80. The Committee also took into account the observation of J Collins in *Nandi v GMC [2004] EWHC 2317 (Admin)* that: "*The adjective 'serious' must be given its proper weight and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners.*"

81. The Committee considered that Registrant's actions reached the threshold of misconduct as he:

a. amended patient prescriptions for his own benefit.

b. used Ms 3 log in details to make the amendments and dispense the medication. This is not only dishonest, but also puts his colleague's professional reputation and job at risk.

c. failed in his duty to speak up when things went wrong. The Registrant should have been honest with his employer during the relevant period in April to May 2023. Amending patient records alters their medical history (which the patient's

would not have known about). This could have impact on those patients' safety or treatment in the future.

d. The Registrant failed to take full responsibility for his actions and engage with the Council's investigation.

e. The Registrant abused his position as a pharmacy professional to access controlled drugs which he removed from his employer without permission. When the Registrant's actions were investigated by colleagues, the Registrant initially denied any involvement or wrongdoing. The Registrant's actions were so serious that they resulted in a criminal caution. This amounts to serious professional misconduct.

82. Further, such actions damage public confidence in the profession, as it would convey a degree of opprobrium to the ordinary intelligent citizen (*Shaw v General Osteopathic Council [2015] EWHC 2721 (Admin)*).

83. The Committee considered whether the Registrant had breached any of the Council's Standards for Pharmacy Professionals (May 2017). 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 establish that the Registrant's fitness to practise is impaired (Rule 24(11)).

84. The Committee determined that there had been a breach of the following Standards as a result of the misconduct:

a. Standard 1 – Pharmacy professionals must provide person-centred care. The Registrant amended patient records, which alters their medical history (which the patient's would not have known about). This could impact patients' safety or treatment in the future.

b. Standard 2 – Pharmacy professionals must work in partnership with others. The Registrant used Ms 3 log in details to make the amendments and dispense the medication. This is not only dishonest, but also puts his colleague's professional reputation and job at risk.

c. Standard 5 – Pharmacy professionals must provide person-centred care. The Registrant amended patient prescriptions for his own benefit.

d. Standard 6 – Pharmacy professionals must behave in a professional manner (in particular, behaving in an honest and trustworthy manner). The Registrant used Ms 3 log in details to make the amendments and dispense the medication. This is not only dishonest, but also puts his colleague's professional reputation and job at risk. Further, the Registrant abused his position as a pharmacy professional to access controlled drugs which he removed from his employer without permission. When the Registrant's actions were investigated by colleagues, the Registrant initially denied any involvement or wrongdoing. The Registrant's actions were so serious that they resulted in a criminal caution. This amounts to serious professional misconduct.

e. Standard 9 – Pharmacy professionals must demonstrate leadership. The Registrant failed to take full responsibility for his actions and engage with the Council's investigation.

85. Accordingly, the Committee concluded that, in its judgement, the grounds of misconduct are established.

Decision on Impairment

86. Having found that the particulars of allegation amounted to a police caution and misconduct, the Committee went on to consider whether the Registrant's fitness to practise is currently impaired.

87. At the outset, the Committee considered the Registrant's insight, remorse, and remediation.

88. The Committee considers that the Registrant has limited insight and remorse. The Registrant has accepted some of the allegations which shows some insight into his behaviour. However, since the imposition of the conditional caution there has been little to no meaningful engagement from the Registrant with the Council.

89. The Committee considers that it has no evidence before it that the Registrant has completed any remediation.

90. The Committee considered whether the particulars found proved show that actions of the Registrant:

a. present an actual or potential risk to patients or to the public;

b. have brought, or might bring, the profession of pharmacy into disrepute;

c. have breached one of the fundamental principles of the profession of pharmacy; or

d. mean that the integrity of the Registrant can no longer be relied upon.

Whether the Registrant's conduct or behaviour present an actual or potential risk to patients or to the public

91. The Committee considers that the Registrant's conduct and behaviour presented an actual risk of harm to colleagues given:

a. There is nothing to assure the Committee that should the Registrant find himself with unfettered access to controlled drugs, that the behaviour would not be repeated.

b. The Registrant falsified patient medication records which could put these patients at risk due to incorrect medical records.

92. The Committee considers that the Registrant's conduct in using a colleague's computer log in, are an abuse of his position of trust as a pharmacy technician. It therefore had the potential to negatively impact upon both standards and effective teamworking in a pharmacy setting. In turn, this presents a potential risk to patients and the public.

93. Given the limited insight and remorse, and lack of remediation completed by the Registrant, the Committee considers that the Registrant's conduct or behaviour may be repeated, which presents an actual or potential risk to patients or to the public.

Whether the Registrant's conduct or behaviour have brought, or might bring, the profession of pharmacy into disrepute

94. The Committee considered that the Registrant's police caution and misconduct has brought the profession of pharmacy into disrepute on the basis that he:

a. Received a police caution for the theft of controlled drugs from his place of work.

b. The Registrant diverted controlled drugs.

c. The Registrant falsified patient medication records for his own benefit.

d. The Registrant, as a pharmacy professional is considered a gatekeeper of controlled drugs and the alleged conduct strikes at the core of his duties and further has the potential to bring the profession into disrepute.

95. Given the lack of insight and remorse, and limited remediation completed by the Registrant, and risk of repetition, as set out in paragraphs 91-93 above, the Committee considers that the Registrant's conduct or behaviour might bring the profession of pharmacy into disrepute in the future.

Whether the Registrant's conduct or behaviour have breached one of the fundamental principles of the profession of pharmacy

96. The Committee considered that the Registrant's conduct and behaviour has breached one of the fundamental principles of the profession of pharmacy, namely:

a. theft of controlled drugs from his place of work.

b. Working whilst potentially having impaired judgement.

c. Diverting controlled drugs.

d. Falsifying patient medication records (for his own benefit).

97. Given the lack of insight and remorse, and limited remediation completed by the Registrant, and risk of repetition, as set out in paragraphs 91-93 above, the Committee considers that the Registrant's conduct or behaviour might breach one of the fundamental principles of the pharmacy profession in the future.

Whether the Registrant's conduct or behaviour show that the integrity of the Registrant can no longer be relied upon

98. The Committee considers that the Registrant's conduct or behaviour show that the integrity of the Registrant can no longer be relied upon for the following reasons:

a. the Registrant's honesty can no longer be relied upon as a result of his theft of controlled drugs from his employer, resulting in his police caution.

b. Falsifying patient medication records (for his own benefit).

c. Diverting controlled drugs.

99. Given the lack of insight and remorse, and limited remediation completed by the Registrant, and risk of repetition, as set out in paragraphs 91-93 above, the Committee considers that the Registrant's conduct or behaviour shows that there has been little to demonstrate that the Registrant's integrity can, again, be relied upon.

Committee's conclusion on impairment

100. In light of the above, the Committee considered the Registrant's fitness to practise to be impaired on the personal element.

101. Further, members of the public would be appalled to learn that a pharmacy technician who had committed theft of controlled drugs at his workplace, worked whilst potentially having impaired judgement, diverted controlled drugs and falsified patient records, without any remediation and little insight, was no longer considered to be impaired. Consequently, the Committee considered the Registrant's fitness to practise to be impaired on the wider public interest element, namely maintaining public confidence in the pharmacy profession and upholding professional standards.

Sanction

102. Having found impairment, the Committee has gone on to consider the matter of sanction. The Committee's powers are set out in Article 54(2) of the Pharmacy Order 2010. 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.

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

104. The Committee had regard to the Council's "*Good decision making: Fitness to practise hearings and outcomes guidance*", published in March 2024 ("Guidance"), to inform its decision.

105. Ms Martin submitted:

a. The mitigating factors in this matter consist of the following:

i. The Registrant accepted the offence in interview; and

ii. The Registrant has no other fitness to practise concerns.

b. The aggravating factors in this matter consist of the following:

i. The Registrant received a police caution;

ii. The Registrant has not engaged with the Council;

iii. The Registrant initially sought to deny any knowledge of the conduct in issue in this case;

iv. The Registrant's conduct had the potential to put patient safety at risk;

v. The Registrant has demonstrated limited insight and no remediation; and

vi. The Registrant attempted to conceal his misconduct by utilising a colleague's log in details with the potential to implicate them in his actions.

c. The sanction imposed should reflect the importance of the public interest and the need to maintain proper professional standards.

d. The sanction imposed should also reflect the seriousness of the criminal offence committed by the Registrant in addition to the misconduct. In this case, the Registrant's actions include the theft of controlled drugs and an attempt to conceal his actions.

e. A warning would be insufficient to mark the seriousness of the Registrant's misconduct and police caution. A warning would undermine the seriousness of the Registrant's conduct when considering the allegations as a whole.

f. Conditions of practise would not adequately address the public interest in these matters nor mark the seriousness of the Registrant's misconduct, and police caution. In light of the Registrant's lack of engagement in these proceedings, the Council has no faith that the Registrant would abide by any conditions imposed on his practise, or that these can be easily monitored. Furthermore, the Registrant was initially given an interim conditions of practice order. However, this was replaced with an interim suspension order on 15 November 2023 after he failed to engage with the conditions.

g. The appropriate and proportionate sanction would be for the Registrant's name to be removed from the Register. The allegations as particularised are so serious that the Council do not consider that a period of suspension even for the longest period would adequately address the seriousness of the misconduct, and police caution. There is a need to demonstrate to the profession and the public, that the conduct fell so far below that expected of a pharmacy professional and considering the aggravating factors in this case, the Council consider removal to be the only appropriate sanction.

h. The Council's guidance on sanctions gives examples of acts of dishonesty which are so serious the Committee should consider removal as the only proportionate and appropriate sanction. Those examples include "*falsifying patient records*". The Committee should also take into account that the Registrant's actions were pre-meditated, repeated and included actions to cover up the wrongdoing.

i. A period of suspension would not protect the reputation of the profession. The Registrant's police caution directly relates to his practice as a pharmacy technician. Upholding the public's trust in the profession and in the Council as a regulator requires the Registrant's removal from the register.

106. The Registrant was not present to make any oral submissions. He provided the following email to the Council on 16 July 2024 in which he said: "*I haven't worked in the pharmacy sector since the incident and I never plan to return so I am more than happy to have my registration revoked and not be able to return*."

107. The Committee agrees with the mitigating and aggravating factors set out by Ms Martin at paragraph 105(a) and (b) above.

108. The Committee considers that the Registrant's current impairment, coupled with limited insight and no remediation, makes taking no action or imposing a warning insufficient to protect the public. Further, these sanctions would not adequately meet the wider public interest of maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour. Therefore, the Committee finds that taking no action or issuing a warning to be inappropriate.

109. The Committee next considered the imposition of conditions of practise to be placed on the Registrant's registration. The Committee did not consider that conditions would be appropriate given:

a. the seriousness of the allegations which involve the Registrant receiving a police caution, theft of medication from the Registrant's workplace, falsifying patient records (putting patient safety at risk), and attempting to conceal his misconduct by utilising a colleague's log in details (with the potential to implicate them in wrongdoing); and

b. no relevant or proportionate conditions could be formulated, or enforced, to mitigate risk from the Registrant repeating his misconduct, given his limited insight and lack of remediation.

Further, the Committee considered that conditions would not adequately meet the wider public interest of maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour.

110. The Committee next considered whether suspension would be a proportionate sanction. However, the Committee did not consider a suspension to be appropriate given:

a. The Guidance which sets out: "*Some acts of dishonesty are so serious that the committee should consider removal as the only proportionate and appropriate outcome. This includes […] falsifying patient records…*". The Committee found that the Registrant falsified two patient records for his own benefit; and

b. The aggravating features of this case set out at paragraph 105(b) above.

111. The Committee next considered whether removal would be an appropriate sanction. The Committee considered removal to be an appropriate sanction given:

a. The Guidance which sets out: "*The committee should consider this outcome when the professional's behaviour is fundamentally incompatible with being a registered professional.*" The Committee considers that the Registrant conduct, as set out at paragraph 110 above is fundamentally incompatible with being a registered pharmacy technician;

b. The Registrant's police caution directly relates to his practice as a pharmacy technician. Upholding the public's trust in the profession and in the Council as a regulator necessitates the Registrant's removal from the register; and

c. Although the Committee gave consideration to a suspension for the Registrant to demonstrate insight and remediation, he failed to engage with conditions and with the Council substantively for these proceedings. Furthermore, he has expressly told the Council that "*I haven't worked in the pharmacy sector since the incident and I never plan to return so I am more than happy to have my registration revoked and not be able to return.*"

112. The Committee therefore directs that the Registrant is removed from the Council's Register.

Interim Order

113. The Committee considered that, pursuant to Article 56(10) of the Pharmacy Order 2010, as it has been determined that the Registrant's fitness to practise is impaired, that the interim order which was in place is revoked.

Decision on Interim Measure

114. Ms Martin made an application for an interim measure of suspension to be imposed on the Registrant's registration, to take effect from today's date, pursuant to Article 60 of the Pharmacy Order 2010, pending the coming into force of the Committee's substantive order. She submitted that in a case of ongoing impairment, such as this case, it is sensible for the Committee to consider imposing an interim measure to cover the appeal period because the Registrant's ongoing impairment places patients, colleagues and public at risk of harm and directly impacts upon the confidence of the public in the profession. She submitted that an interim measure would be consistent with the substantive order imposed by the Committee.

115. In considering Ms Martin's application, the Committee took account of the fact that its decision to suspend the Registrant will not take effect until 28 days after the Registrant is formally notified of the outcome, or until any appeal is concluded.

116. The Committee has found that there remains a risk that the Registrant might repeat his conduct, if permitted to return to work unrestricted. It accepted the submissions of Ms Martin that the Registrant's unrestricted registration would place patients, colleagues and the public at risk of harm and have an impact on public confidence, and it was satisfied that it was necessary for an interim measure to be put in place to protect the public and safeguard the public interest during the appeal period.

117. The Committee notes that an immediate suspension will impact upon the Registrant's professional and personal life, but this impact is outweighed by the need to protect patients, colleagues and the public and the wider public interest.

118. The Committee is satisfied that it is therefore appropriate for an interim measure to be in place prior to the taking effect of the substantive order.

119. The Committee hereby orders that the entry of the Registrant in the register be suspended forthwith, pending the coming into force of the substantive order.

120. This concludes the determination.