General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote videolink hearing

16-23 December 2024

Registrant name:	Sithembile Sibanda
Registration number:	2220573
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Neville Sorab (Chair) Esosa Osakue (Registrant member) Roseann Kane (Lay member)
Committee Secretary:	Sameen Ahmed / Gemma Staplehurst
Registrant:	Not present and not represented
General Pharmaceutical Council:	Represented by Olivia Rawlings, Case Presenter
Facts proved:	1, 1.1, 1.2, 2.1, 2.2, 3, 3.1, 4.1, 4.2, 5.1, 6.1, 6.2, 7, 9, 9.1, 9.2, 10, 11
Facts proved by admission:	None
Facts not proved:	7.1, 7.2, 8
Fitness to practise:	Impaired
Outcome:	Removal
Interim measures:	Interim Suspension

This decision including any finding of facts, impairment and sanction is an appealable decision under *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010*. Therefore, this decision will not take effect until Monday 20 January 2025**.** However, the interim suspension set out in the decision takes effect immediately and will lapse when the decision takes effect or once any appeal is concluded.

Particulars of Allegation (as amended)

You, a registered pharmacist (2220573):

1. *On or before 2 February 2023, submitted two CPPE clinical assessments which had not been completed under the supervision of a clinical mentor or clinical supervisor; and,*

    1.1. *The two case-based discussion assessments you submitted to CPPE (CbD1 and CbD2) were different from those on record with the clinical mentors who undertook those assessments with you;*

    1.2. *The clinical supervisor you listed on your two MR-CAT assessments, Colleague A, did not complete those assessments with you.*

2. *Your actions in 1 were dishonest in that you:*

    2.1. *Knew that the two-based discussion assessments you submitted to CPPE (CbD1 and CbD2) were different from those on record with the clinical mentors who undertook those assessments with you;*

    2.2. *Knew that the clinical supervisor you listed on your two MR-CAT assessments, Colleague A, did not complete those assessments with you.*

3. *During your employment with The Northamptonshire Health NHS Foundation Trust, you provided incorrect reasons as to why you were uncontactable during a period of sick leave in that you:*

    3.1. *informed Colleague B on 31 October 2022 that it was due to your personal and work phone being damaged by a water leak at Rushden Medical Centre.*

4. *Your actions in 3 and 3.1 were dishonest in that you:*

    4.1. *Knew that the explanation provided was untrue;*

    4.2. *Intended to mislead Colleague B.*

5. *In an end of probation meeting with Colleague C on 18 April 2023, you provided inaccurate information in that you:*

    5.1. *stated that your last day working for The Northamptonshire Health NHS Foundation Trust was 07 April 2023.*

6. *Your actions in 5 and 5.1 were dishonest in that you;*

    6.1. *Knew that you left with The Northamptonshire Health NHS Foundation Trust on 10 January 2023, and had not worked any shifts for them since that date;*

    6.2. *Intended to mislead Colleague C.*

7. *In the course of your employment with the Primary Care Network at Northamptonshire Healthcare NHS Foundation Trust between 17 May 2021 to 10 January 2023, you reported CPPE training commitments during working hours to your workplace, Rushden Medical Centre; and*

    7.1. *The hours you declared that you had out-of-practice training were in excess of your actual commitments; and,*

    7.2. *You took unauthorised absences from work on the basis of these exaggerated or non-existent commitments.*

8. *Your actions in 7, 7.1 and 7.2 were dishonest in that you deliberately exaggerated the extent of your CPPE training commitments, in order to take time off from work to which you knew you were not entitled.*

9. *On 30 March 2023, you dispensed both Ramipril and Candesartan to a service user;*

    9.1. *This service user has a documented allergy to Ramipril; and,*

    9.2. *There is a negative pharmacodynamic interaction between Ramipril and candesartan, and these drugs should not be prescribed together.*

10. *Failed to keep adequate records of the medication reviews set out in Schedule 1.*

11. *Failed to request and or undertake appropriate interventions and / or follow up actions in respect of the consultations conducted in Schedule 1.*

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

Documentation

Document 1- Council hearing bundle

Document 2- Council skeleton argument on amending allegations

Document 3- Council Statement of Case

Document 4- Council Chronology

Document 5- Schedule 1

Document 6- Council Proof of Service bundle

Document 7- Council Proceeding in Absence bundle

Witnesses

Ms 1 – gave evidence at facts stage

Ms 2 – gave evidence at facts stage

Colleague C – gave evidence at facts stage

Mr 1 – gave evidence at facts stage

Colleague B – gave evidence at facts stage

Determination

Introduction

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

2. The 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 outcomes 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.

Service of Notice of Hearing

6. The Committee has seen a letter dated 12 November 2024 from the Council headed "Notice of Hearing" addressed to the Registrant. The Notice of Hearing was sent more than 28-days prior to the commencement of the hearing, stated the date, time and venue of the hearing, and also contained the finalised particulars of the allegation. The Committee was satisfied that there had been good service of the Notice in accordance with Rules 3 and 16.

Application to proceed in the absence of the Registrant

7. The Registrant was not in attendance at this hearing, nor was someone attending on their behalf. The Committee heard submissions from Ms Rawlings, on behalf of the Council, to proceed in the absence of the Registrant under Rule 25, on the basis that:

   a. There has been good service and contact has been attempted by telephone. The case papers have been sent to the Registrant via Egress (encrypted email), but had not been opened by the Registrant. There has been no response from the Registrant. In the circumstances, the Registrant has voluntarily absented herself;

   b. No adjournment has been sought by the Registrant and, in any case, an adjournment would not secure the attendance of the Registrant; and

   c. It is in the public interest to proceed in the absence of the Registrant.

8. The Committee decided to proceed in the absence of the Registrant for the following reasons:

   a. The Committee has found good service of the Notice. The Registrant is aware of today's proceedings. The Committee has therefore considered that the Registrant has chosen to voluntarily absent themselves from this hearing.

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

   c. There is a public interest in the expeditious disposal of cases.

Preliminary matters – fairness of the proceedings

9. At the outset of the hearing, the Committee expressed its concern at the difficulty of following the witness statements of Ms 2, Colleague B, and Mr 1 due to the redactions in these documents. Ms Rawlings conceded that the redactions made the witness statement of Ms 2 hard to follow.

10. The Committee invited the Council to provide it with less heavily redacted versions of the witness statements and attached exhibits, balancing privacy and the ability to follow the documents. The Committee also asked Ms Rawlings whether the Registrant received the same heavily redacted documents, to which Ms Rawlings said that the Registrant did. The Committee invited submissions from Ms Rawlings as to whether

the heavily redacted witness statements of Ms 2, Colleague B, and Mr 1 resulted in an inability of the Registrant to fully understand the evidence against her. Ms Rawlings said that it did not on the basis that:

a. The Registrant has not opened any of the documents provided to her;

b. The redactions in the witness statement of Colleague B are minor and would not affect the Registrant's understanding of the case against her; and

c. An unredacted version of Ms 2's and Mr 1's witness statements and attached exhibits can be sent to the Registrant on 16 December 2024 to allow her sufficient time, should she attend, to prepare for any cross examination on 17 December 2024.

11. The Committee determined that the fairness of the proceedings would not be compromised given that:

a. The Registrant has not opened any of the documents provided to her;

b. The redactions in the witness statement of Colleague B are minor and would not affect the Registrant's understanding of the case against her; and

c. If the Registrant was present at the hearing, she could cross-examine Ms 2 and Mr 1 on the text behind the redactions.

12. Although she has been absent to date, the Committee considered that should the Registrant wish to participate in the proceedings, that an unredacted version of Ms 2 's and Mr 1s' witness statements and attached exhibits should be sent to the Registrant before the close of business on 16 December 2024 to allow her sufficient time, should she attend, to prepare for any cross examination on 17 December 2024. The Committee considered that this would be sufficient time given that the Registrant had already been given the witness statements of Ms 2's and Mr 1's and attached exhibits, albeit redacted. The Committee received confirmation from the Council that the Registrant was emailed the amended witness statements of Ms 2 at 12.05pm and Mr 1 at 1.30pm on 16 December 2024.

Application to amend the particulars of allegation

13. The Committee heard an application from Ms Rawlings under Rule 41 to amend allegations 1.1, 1.2, 2.2, 3.1, 4.2, 5 and 6.2 so that the names of individuals are anonymised.

14. Ms Rawlings submitted that amending the allegations in this way would not prejudice the fairness of the proceedings as their substance is not being altered. They are merely presentational amendments for the sake of the privacy of those individuals who are named. The proposed amendments are not based on new evidence. For those reasons, there will be no prejudice caused to the Registrant if the application is granted.

15. The Registrant was not present to oppose the application.

16. The Committee accepted that, subject to the requirements not to prejudice the fairness of these proceedings, the allegations should reflect the gravity of the Registrant's alleged conduct or behaviour (*PSA v HCPC and Doree [2017] EWCA Civ 319*). However, to introduce late an entirely new case requiring extensive investigation would potentially be unfair (*Bittar v FCA [2017] UKUT 82 (TCC)*). The Committee was of the view that the amendments to the allegations reflect the evidence, and are presentational amendments for the sake of the privacy of those individuals who are presently named. The amendments are not based on new evidence and are not material to its substance. Consequently, the amendments would not prejudice the fairness of these proceedings.

17. The Committee accepted the application to amend the particulars of allegation.

Application to admit further evidence

18. On 16 December 2024, Ms Rawlings made an application for the Committee to admit a statement from Ms Neha Ramaiya which was exhibiting documents. Ms Rawlings submitted that the relevant document exhibited by Ms Ramaiya had already been sent to the Registrant twice; once in the Rule 14 bundle, and also in the 16-day bundle. As the Registrant has had sight of the relevant document exhibited by Ms Ramaiya, there was no risk or prejudice suffered by the Registrant by the admission of the witness statement from Ms Neha Ramaiya and exhibiting documents.

19. The Registrant was not in attendance to support or oppose the application.

20. The Committee noted rule 18(5) which set out: "*Any document which has not been served on the secretary by the end of [No later than 9 days before the Monday of the week in which the hearing is to take place] is, except in exceptional circumstances, not to be admitted into evidence at the hearing.*" Should the Committee consider that the "*exceptional circumstances*" have been met, then the evidence needs to be relevant and fair (Rule 24(2)).

21. The Committee denied the application on the basis that "*exceptional circumstances*" had not been met on the basis that the request to admit Ms Neha Ramaiya statement and accompanying documents was being made solely to introduce a single exhibit from Ms Ramaiya. This document was in the possession of the Council prior to the 9-day bundle deadline; the Council understood its importance; and the Council failed to admit the document in the 9-day bundle.

Background

22. The allegations relate to the Registrant's time as both a learner on the Centre for Pharmacy Postgraduate Education ("CPPE") general practice pathway, and whilst

employed with The Northamptonshire Health NHS Foundation Trust ("The Trust") and Saffron Group Practice. It is alleged:

a. in relation to her CPPE course, that the Registrant fabricated coursework.

b. during the course of her employment at the Trust, the Registrant invented reasons for absences and for being uncontactable, as well as providing incorrect information to employers who were attempting to investigate concerns regarding the Registrant.

c. the Registrant made poor clinical decisions.

d. the Registrant kept poor record keeping over a period of time.

e. the Registrant made errors when prescribing medication.

Evidence

23. Ms 1 provided the following evidence:

a. She is a Senior Clinical PCN Pharmacist, and oversees East Northants PCN.

b. She runs the practice SMR clinics and hypertension clinics. She manages new starters to the PCN, ensuring that they are working to the required standard, and helping to meet any education needs that they have. She also manages Pharmacy Technicians and foundation trainee pharmacists doing cross-sector training.

c. New pharmacists have consultation practice with CPPE, which is supplemented by additional supervision by the practice. As Area Lead, Ms 1 goes around to different practices within the network to deliver this supervision. The Registrant fell within her remit. She provided supervision to the Registrant on two occasions.

d. In this supervision, Ms 1 and the Registrant discussed various points of development including delving deeper into patients' background and mental health, and asking more of those types of questions. There were anticipated gaps in the Registrant's knowledge because she was a new starter. Ms 1 had no concerns at that point as she was a new starter from another sector, and this supervision was intended to develop her skills in new ways.

e. Ms 1 is a student on the MSc Advanced Clinical Pharmacy Practice course, and as part of the course she is required to conduct research. She researched pharmacists working in PCN contexts, and whether carrying out Structured Medication Reviews had a positive impact on patient outcomes. To undertake this assessment, Ms 1 used the work of two pharmacy professionals who were at same point in their CPPE training – one these was the Registrant. The patient records were all drawn from the period October 2021 to October 2022, patients were randomised, and sample size relevant to those records was selected. Ms 1 reviewed a small number of the Registrant's records as part of this research, but stopped soon after. This is

because there were consistent issues with the quality of the work which would not be reflective of the standard of pharmacists in general. The quality of the Registrant's work was so low that the data for Ms 1's research would have been skewed. There was a large difference between the quality of work of the two pharmacists. The other pharmacist was not exceptional, but just at a position where Ms 1 would expect a pharmacist of that experience (which was the same as the Registrant's experience) to be.

f. The Registrant's earlier consultations were good, but as time went on there was a lack of documentation in the patient records. Over time, the Registrant would increasingly just complete the form's tick boxes, which asked very simple questions such as "*Is this an SMR?*". Reading many of these forms, Ms 1 gained no additional knowledge about how the patient was, how they felt about their medication and any proposed changes, or any side effects they may have been experiencing. This decline in quality was evidenced gradually over time; the Registrant's work became worse from about March/April 2022 until she stopped working at the practice altogether. In several cases, the patient would clearly have benefited from blood tests, but there were patients who had gone in excess of six months without a blood test. The contextual detail received from patients would provide a holistic picture of patients which was missing from the Registrant's reports.

g. There were also instances where risk factors were recorded, but no actions were taken in respect of them. It is unclear why blood tests were not ordered for some of these patients, when this is the bare minimum that should be carried out. In one instance, a patient on ACE inhibitors presented with high blood pressure, but no questions appear to have been asked and no plan was put in place to assess this patient's blood pressure over time. If a single high blood pressure reading is reported by a patient, a responsible pharmacist should have checked the factors surrounding this. These include whether this was taken before or after medication, after the patient had coffee, whether they were rushing around at the time, if it was taken by paramedic during a medical incident, etc. If no such factors applied, a pharmacist might have suggested taking a sample of blood pressure readings morning and night over consecutive days. With these, the pharmacist could calculate an average blood pressure, and provide the patient with medication and lifestyle advice if this was high. An ECG and blood test should have been ordered. QOF (the Quality and Outcomes Framework guidance) instructs that anybody on an ACE inhibitor needs to have a blood test within a year to mitigate the risk of kidney failure or high potassium levels.

h. Beyond deviating from best practice, the consultations carried out by the Registrant presented a patient safety issue – failure to make the right interventions creates a heightened risk of problems for patients such as kidney issues, stroke, or arrythmia.

i. Based on Ms 1's concerns about the records kept by the Registrant that she reviewed, Ms 1 prepared an Excel document in which she synthesized the issues

identified and basic information – Schedule A. Ms 1 captured several factors on the document considered to be relevant to the assessment of the risk and seriousness of the concern:

i. One patient was a 57-year-old on 6 medications, including hydroxychloroquine. The Registrant gave this patient lifestyle advice, which was a good intervention, but she did not check if was the medication regime in place was actually working. Amitriptyline has an anticholinergic burden, which means that users have an increased risk of falls. The opportunity to deprescribe some of these medications was not explored or taken.

ii. Another patient was a 71-year-old on 11 medications, including gliclazide. No interventions were undertaken in respect of this patient – there was no deprescribing, and blood tests were not ordered. Gliclazide is falling out of favour as a medication to treat diabetes in patients without osmotic symptoms. The Registrant did not ask this patient about her blood pressure or mobility; given the patient's age and prescription, these were missed opportunities. Gliclazide also carries a risk of hypoglycaemia. Other medications with lower associated risks are now available – no conversation about this was recorded with the patient, however.

iii. In one 55-year-old patient, blood pressure was not asked and, although they were on ACE inhibitors, no blood test was done.

iv. For another 74-year-old patient, however, a blood test and blood pressure check are recorded as ordered. It appears that sometimes these necessary interventions are done, sometimes not.

v. Some optimisation was provided for a 94-year-old patient, who was provided with dissolving tablets because they could not swallow their existing prescription. They were referred to a dietitian for the weight loss they were presenting, which was a good intervention. Consideration should have been given to a further GP referral to exclude other possible concerns (cancer, etc), but this was not documented. More concerningly, there is no mention of questions about lifestyle such as eating or drinking habits in the patient notes. They were also on apixaban (blood thinner), but there was no pulse check undertaken.

vi. For a 72-year-old patient on 12 medications, no pulse check or blood tests were ordered although these should have been.

vii. A 75-year-old patient on a Reletrans patch (pain patch) and an additional 5 medications had no blood pressure test undertaken, nor was his number of medications reduced. Opioid-based pain medicines elevate the risk of falls in patients. Questions about whether they have they been to pain clinic or undertaken a pain course would have assisted in optimising their medications more effectively.

viii. Some good interventions were made in the SMR completed for a 76-year-old patient. His inhaler stopped as this was no needed, and a blood test was ordered as appropriate. More questions about monitoring needed to be asked, however – the patient needs to understand key points such as the circumstances under which they need to go back to hospital, and what it means to have fluid in their legs.

ix. A 76-year-old patient on 14 medications including high-risk drugs (apixaban, xultophy) was referred to the community diabetes team and to their GP for blisters. These good interventions were the result of a more thorough consultation; this is an example of the Registrant's work before it began to decline in Spring 2022.

j. It is unclear to Ms 1 how or why this deterioration in the quality of the Registrant's work happened, as she was getting ongoing support from her GP surgery, Rushden Medical Centre. The GP practice had to extend themselves to arrange this support, but did so and this supervision was being provided. Colleague B also tried to support the Registrant in the best way possible.

k. When the concerns relating to the Registrant's conduct and attendance were raised, on multiple occasions there were attempts to address these with her; Colleague B and Ms 1 called the Registrant multiple times, but the Registrant would not answer her phone. Ms 1 managed to reach the Registrant after the first meeting had been missed. In this call, Ms 1 told the Registrant that Colleague B, as her manager, wanted to make sure everybody was on the same page and that she was being supported. Ms 1 asked the Registrant if she was willing to have that conversation, and she responded saying "*yeah that's fine*". Despite re-arranging calendars, the Registrant did not turn up and made no acknowledgement of the efforts that were being made on her behalf. Communication was tried through email, phone, post, but the Registrant would not communicate. This failure to engage is not how a professional is meant to behave. At this point, the Trust was not yet aware of the clinical issues present in the SMRs, and the meetings were solely in respect of the training attendance discrepancies.

l. The Registrant did not undertake standard practice for pharmacists in PCN, which created a risk of harm to patients, including an increased risk of falls, strokes, or heart attacks. Ms 1 looked at another CPPE learner's work to see if patients are receiving consistent level & quality of service, and found that the standard was the same as her own. The service provided to patient should be even across staff.

m. The Registrant was given the requisite training and support.

n. No incident report was filed in respect of these difficulties, and it was not possible for the Trust to undertake an investigation under the given circumstances.

o. When Ms 1 had been in contact with CPPE during the Registrant's employment, they had said that she was taking more time out of her practice schedule than necessary to do her CPPE work. The discrepancies in the time she was taking off

were picked up by the practice and the PCN, and were cross-checked with the dates provided by CPPE. Ms 1 does not know why the Registrant said that days she had taken off were CPPE training days when they were not.

24. Ms 2 provided the following evidence:

a. She is the Lead Pharmacist Primary Care Pathways for the Midlands and East of England area. In her role, she supports Education Supervisors, who in turn support learners through their 18-months CPPE pathways to have an effective learning experience throughout the five modules of the pathway.

b. Education Supervisors may bring matters to the attention of their Regional Lead where learner milestones are not reached, pastoral issues arise, or they view that additional learner support is needed.

c. The Registrant was enrolled on PCPEP, an 18-month CPPE pathway, which is delivered through 5 modules. Additional Roles Reimbursement Scheme funding is available through NHS England to recruit pharmacy professionals to work in Primary Care Networks. A condition of this funding is that the pharmacy professionals undertake the PCPEP and following the pathway the Independent Prescribing ("IP") course for pharmacists who are not already qualified as independent prescribers. The IP course is demanding, and it is normally taken at the conclusion of the 18-month pathway; provision exists for those with strong clinical experience to apply for the IP module at an earlier stage.

d. Concerns relating to the falsification of documents on the CPPE PCPEP pathway were brought to Ms 2's attention by the Registrant's Education Supervisor. In her email of 1 February 2023, Ms Sibanda was ready to submit her final statement of assessment and progression known as the "SoAP", but she did not have a copy of the Case based discussion (CbD 1) assessment form to upload to her e-portfolio. It is a requirement of the SoAP review process that all assessment forms are uploaded to the e-portfolio for the education supervisor to review and award the SoAP if all the learning is complete.

e. The completed CbD 1 form submitted by the Registrant listed a pharmacy technician, Lianne Clarke, as the Registrant's Clinical Mentor; however, a pharmacy technician and is not eligible to be a Clinical Mentor that would assess a Case based Discussion. In her witness statement, Ms 2 said that "Lianne Whitehead" was listed as the Registrant's Clinical Mentor on the form. One of the CbD forms names the assessor as "Lianne Clarke". In her oral evidence, Ms 2 confirmed that "Lianne Whitehead" and "Lianne Clark" are the same person. The completed CbD 2 form submitted by the Registrant listed the Registrant's clinical mentor for CbD 2 as "L Panray" who is not a clinical mentor for CPPE. Clinical mentors, rather than clinical supervisors, would assess CbDs.

f. Clinical Mentors who assess learners' CbD presentations can only be senior clinical pharmacists (not pharmacy technicians). By contrast, Clinical Supervisors are provided by the learner's employer; they provide learners with day-to-day support

with clinical issues plus role progression and are a point of contact for escalating issues. Clinical Supervisors are responsible for conducting workplace-based assessments, in particular the CPPE Medicines Related Consultation Assessment Tool ("MR-CAT") and the Clinical Examination Procedural Skills Assessment Record ("CEPSAR").

g. After finding the issues with the CbD documentation, Ms 2 asked another person to look at the other assessment documentation included in the Registrant's statement of assessment and progression to see if there were any further anomalies. This person noted that the handwriting in the MR-CAT form which should be completed by the clinical supervisor was similar to the registrant's own handwriting. On 6 February, Ms 2 contacted the Registrant's clinical supervisor, Colleague A, to confirm whether the handwriting on the MRCAT consultation skills form was his. He confirmed via email that the handwriting was not his.

h. On 8 February, the National Lead for primary care pathways emailed the Registrant laying out concerns and requesting acknowledge receipt of that email within two working days and reply within a fortnight. No reply was received. The contents of the email were sent via recorded letter to the Registrant's home address.

i. At the time that concerns were brought to Ms 2, it was not clear where the Registrant was working. When the learner applied for the 18 month pathway, the Registrant was working at Northamptonshire Healthcare NHS Foundation Trust as a Pharmacist.

j. As the Registrant had not replied to either email or letter, the next step would be to write to the Registrant copying in their line manager. Ms 1 confirmed the Registrant was no longer working for the Trust but was working for Leicester South PCN. Through various enquiries CPPE established the Registrant was working at Saffron Group Practice, within Leicester South PCN.

k. Ms 2 was advised that in January or February, the Registrant moved to Saffron Group Practice, and was directly employed by the practice, rather than the PCN using ARRS funding. Saffron Group Practice knew that the Registrant was on the CPPE pathway and there was an expectation that she would complete the pathway, as she had only the SoAP to complete to finish the entire pathway. If a new employer is able to support a CPPE learner by accommodating time away for external training, providing them with patient-facing experience, and meeting other requirements, then there is no issue with learners changing employers mid-pathway, even if there are different funding arrangements for the role.

l. On confirmation that Colleague C was the Registrant's new line manager, the original email sent by on 8 February 2023 was forwarded to the Registrant's home and NHS email address copying in Colleague C, with a brief summary of events, requesting she make contact urgently.

m. The Registrant made contact with CPPE the following day and agreed to a meeting with Ms 2. A summary of the discussion was later shared with Colleague C and the Registrant.

n. The Registrant had left her previous role and was working for Saffron Group Practice by the time concerns with the Registrant's SoAP had been raised within CPPE.

o. In her conversation with Ms 1, Ms 2 was made aware of a number of issues involving the Registrant which had arisen prior to her departure from the Trust. Ms 1 told Ms 2 that the Registrant started the role "*really engaged*" and she and other senior pharmacy personnel were impressed by the Registrant; but the Registrant then reached a "*tipping point*" where her engagement dropped off. I was advised that there was concern that the Registrant had [health issues], "*wasn't engaged at work*", and was missing meetings at short notice or without warning.

p. Ms 2 believes that it was in correspondence between Colleague C and the Registrant regarding the concern about 5 April 2023 that the Registrant remarked that CPPE had not responded quickly enough to her issues with obtaining her original assessment documents. Ms 2 had responded on 2 February 2023, the same day that Ms 2 had been made aware of the issue. After becoming involved in the correspondence, Colleague C then also had concerns.

q. The Registrant's dishonesty in relation to the clinical documents came about because, although CPPE was already aware that she had passed her assessments due to records logged by her assessors, she was required to upload the completed assessments to the learner e portfolio to progress. Because she did not have immediate access to her completed assessments, she fabricated new ones for submission. Initially, CPPE's concerns in relation to the Registrant were that her documentation was falsified. From a patient risk perspective, this conduct was not a cause for concern *per se*, but by the Registrant's own admission demonstrated poor judgement. The Registrant's selection of a name of somebody from CPPE to list on her assessments is one that is factually incorrect, as admitted by the Registrant. Ms 2's impression is that the Registrant wanted to complete the pathway so that she could progress to start the IP course and do only one course at a time; consequently, she falsified documentation for the purpose of completing the CPPE pathway quickly.

r. The Case-based Discussion #1 ("CbD1") forms that the Registrant submitted and that her assessor had were different. Ms 2 obtained the form from the Registrant's assessor by emailing them directly. This evidences a definite attempt by the Registrant to falsify this assessment. Each form was exhibited.

s. The Case-based Discussion #2 ("CbD2") forms that the Registrant submitted and that her assessor had were different. Ms 2 obtained the form from the Registrant's assessor by emailing them directly. Only the form obtained by the assessor was exhibited.

t. If the Registrant had been genuinely unable to upload her completed documents, the matter would have been handled differently had there been transparency. Because all parties knew that the Registrant had already passed her assessments, decisions would need to have been brought to Ms 2 and shared with the Assessment Lead to find a solution. Given the Registrant's near-completion of the pathway and records indicating that she had completed and passed all of her assessments and that Ms 2 had original documents from the assessors, Ms 2 views it as highly unlikely that the Registrant would have been required to do the assessments again.

u. However, due to the concerns raised regarding the integrity of her CbD1 and CbD2 submissions, a review of all of her assessment submissions was completed by her Education Supervisor following her discussions with Ms 2. In the review, it was noted that the assessor handwriting on both of the Registrant's MR-CAT assessments dated 10 November 2022 (exhibited) and dated 14 November 2022 (exhibited) was very similar to the Registrant's, as captured in her CEPSAR record. In her oral evidence, Ms 2 confirmed that she has no experience in handwriting analysis.

v. Ms 2 contacted Colleague A by phone to confirm his involvement in the Registrant's assessments. He informed her that he had signed the Registrant's CEPSAR record and been involved in that assessment, but that he had not been involved in her MR-CAT assessments. Ms 2 subsequently received confirmation in writing from Colleague A that the writing on the MR-CAT assessment form was not his own (exhibited).

w. When CPPE National Lead and Ms 2 held a meeting with the Registrant on 21 March 2023, the Registrant was asked about the signature discrepancy. The Registrant responded that it was not Colleague A but another GP who had completed her MR-CAT assessments. During the meeting, CPPE questioned the Registrant about this alternative GP assessor by email. The Registrant said that her clinical supervisor, who Ms 2 confirmed to be Colleague A, was "*uncontactable and unreachable*". Colleague A and the Registrant had finally reached a date to conduct the assessment, but Colleague A did not show up and the Registrant needed to find a new assessor. The Registrant said that as the surgery did not employ any permanent GPs, she asked a locum to do so. Ms 2 did not ask Colleague A if he was contactable or not.

x. The Registrant produced a reflective statement, which Ms 2 asked her to complete in response to CPPE's concerns, about the veracity of her assessment documents (exhibited).

y. Ms 2 notes that if there had been more self-awareness from the Registrant or an apology, CPPE would have been more prepared to move forward from this issue. In her meeting with Ms 2, the Registrant seemed bored and almost flippant, and felt that she was "*going through the motions*". Ms 2 formed the impression that

there was no remorse for her conduct, and that she did not seem to care about its implications.

z. Both MR-CAT assessments bear Colleague A's name, and have retroactively been attributed to an unidentifiable locum GP by the Registrant. Consequently, there is no proof that either was actually completed by a GP. For clarity, while the forms have been completed with reference to a "*GP Mentor*", the MR-CAT forms should list a "*Clinical Supervisor*" as the assessor.

aa. At the time that this concern was raised, Ms 2 was in communication with Colleague C and Ms 1; Ms 2 is no longer in contact with either party regarding this matter. The concern about the Registrant's assessments had been raised with Health Education England (now NHS England), which is awaiting the GPhC's decision to decide on further action. The Registrant has not been signed off or removed from the CPPE pathway which she was due to complete – her progress has been paused while the matters are reviewed by the GPhC.

bb. Ms 2 is concerned that the assessment process has not been followed by the Registrant, who is bound by certain standards as a GPhC professional. At the same time, Ms 2 understands that some people might panic in the Registrant's position if they were unable to submit their assessments.

cc. The tipping point in Ms 2's management of this concern was when Ms 1 contacted her and asked whether there had been any update on the Registrant's progression on the CPPE pathway. In Ms 2's phone call to Ms 1, Ms 1 informed Ms 2 that new clinical concerns relating to the Registrant's work had come to light during Ms 1's research. This was disclosed to Ms 2 as the purpose of the CPPE pathway is to ensure patient safety.

25. Colleague C provided the following evidence:

a. The Registrant was employed as a Clinical Pharmacist at Saffron Health from 17 January 2023 to 25 April 2023.

b. Saffron Health first became aware of issues relating to the honesty of the Registrant on 20 March 2023 when we were contacted by the CPPE pathway tutor in relation to the documents the Registrant had submitted as part of her CPPE pathway. Saffron Health then identified its own additional concerns regarding one of the statements included in the Registrant's reflective statement which was raised with the Registrant on 4 April 2023 during a phone meeting.

c. After the meeting on 4 April 2023, Saffron Health took the decision on 5 April 2023 for the Registrant not to do any further patient-facing work and to focus on audit and MHRA alert work only.

d. Saffron Health has investigated these concerns by meeting with the Registrant and also then corroborating information with the CPPE pathway tutor as well as the Independent Prescribing Programme Lead at University of West of England. Saffron

Health has also subsequently undertaken a review of all the patient records that the Registrant accessed during her employment with the practice.

e. The clinical review has identified:

    i. One initial case of concern identified by the Lead Prescribing GP in which the Registrant had issued ramipril and candestartan to an elderly patient with sensitivity to ramipril. It was documented in the patient's records that they were allergic to ramipril.

    ii. A review of all 142 records accessed by the Registrant during her employment by the Prescribing Lead GP. Access to the records was justified for all cases. A summary of the findings is below:

        1. 34 records were considered as N/A or failed encounter. This meant that the patient could not have been contacted.

        2. 83 records showed no concerns.

        3. 5 records showed either blood tests or urine tests had not been arranged.

        4. 1 record showed a clinical issue that had been missed.

        5. 6 records showed either an incomplete medication review or consultation.

        6. 4 records showed incorrect data entered in the record.

        7. 2 records showed information that had not been entered into the record.

        8. 7 records showed medication errors.

    iii. Of these, the Prescribing Lead GP considered the one case described in the end of probation meeting as significant with the remaining cases of less significance in terms of patient safety. No harm has come to any patients that Colleague C was aware of as a result of these issues and the Prescribing Lead GP has confirmed that all issues have now been rectified by the practice.

f. Colleague C was then informed of concerns relating to clinical competency by Saffron Health's Lead Prescribing GP on 18 April 2023, in an end of probation meeting, in relation to the one case that had been identified. On the same day, the CPPE pathway tutor contacted Colleague C to highlight clinical concerns identified by the Registrant's previous employer.

g. Colleague C took minutes of the 18 April 2023 end of probation meeting but were not signed or acknowledged by the Registrant despite them being emailed to her. Colleague C confirmed that they were an accurate reflection of the meeting.

h. During the end of probation meeting on 18 April 2023, Saffron Health's concerns were outlined and the Registrant was told that a decision would be made regarding her employment by the end of the week. The Registrant emailed her resignation within an hour of the meeting ending. Due to the ongoing concerns, her resignation was accepted and she was placed on garden leave for her notice period. Her last day of employment with Saffron Health was 25 April 2023.

i. Colleague C notified both the CPPE pathway tutor and also the Programme Leader for the Independent Prescribing course at the University of the West of England of the Registrant's resignation from the practice.

j. The Registrant was asked to focus on QOF work when she started with the aim of broadening out her role once we had come to the end of the QOF year and in line with her ongoing IP training. She had an induction period when she started at Saffron Health during which she sat in with other experienced pharmacists and was also assigned a GP mentor who she met with regularly and also acted as her supervisor for the Independent Prescribing course.

k. The Registrant had access to the other pharmacists and GPs at all times while she was working with Saffron Health.

l. The Registrant was released from the practice to attend IP training sessions for a total of 8 days and was also allocated shadowing time for her IP course with GPs, nurses and another pharmacist.

26. Colleague B provided the following evidence:

a. He is the Primary Care Networks Pharmacy Team Manager. The Northamptonshire Health NHS Foundation Trust provide a PCN service, and he is the lead pharmacist responsible for the day-to-day running of the pharmacists in the Trust's GP practices.

b. He was the Registrant's line manager while she was employed by the Trust. While she was his direct report, she was also accountable to various people, in particular her GP supervisor and the practice manager at Rushden Medical Centre. CPPE learners must have a GP supervisor**,** who provides day to day oversight in the workplace. Matters such as annual leave or sick leave would be negotiated by the Registrant and the Practice Manager, Michelle Cooper.

c. One of the terms of the Registrant's employment was that she needed to complete the CPPE Primary Care pathway – this is stipulated in the job description and the additional training was Additional Roles Reimbursement Scheme ("ARRS") funded. The purpose of this funding is to upskill pharmacists to work in a GP surgery setting, which is an area of practice which is not addressed by higher education in pharmacy.

d. The Registrant was employed by the Trust from 17 May 2021 to 10 January 2023. She was on sick leave from 20 Oct 2022 through to the end of her notice period.

e. The Registrant was deployed to a GP surgery, Rushden Medical Centre. This is where she worked Monday to Friday and spent almost all of her time. The only time she worked elsewhere was at the beginning of her contract, when she visited other GP practices shadow other pharmacists, and learn how to complete tasks like paper reviews and medication reviews.

f. As a CPPE learner, Ms Sibanda is supposed to have 4 hours a month of supervision with her GP Supervisor; however, this number is variable depending on the skills of the pharmacist. Often, new starters begin the role needing more than 4 hours of supervision and develop to needing less than 4.

g. Rushden Medical Centre is an independently-owned practice and has a complex structure. Their senior clinicians and practice manager are employed directly by the practice. Trust pharmacists are employed by the NHS Trust, but deployed to the GP surgery through the PCN scheme.

h. Colleague B did not work onsite at the GP surgery, but as the Registrant's direct manager, he would visit the Registrant once per month to check in with her about her well-being and development. This HR process could be carried out onsite or virtually. Colleague B would also be in contact with the Registrant on other occasions, for example when there were requested absences.

i. At the beginning of the Registrant's employment with the Trust, there was nothing remarkable or concerning to note. There was some difficulty with getting the necessary supervision time from her GP practice. This supervision can be done by any GP, but ideally will be delivered by the allocated GP supervisor.

j. Colleague B became aware of the Registrant's lack of attendance on 5 Oct 2022, when the practice manager Michelle Cooper contacted him by email to request a call. Ms Cooper advised Colleague B that that the Registrant had been absent frequently from the GP practice, commenting that they "*don't see her a lot*" and that she "*had a lot of training days*". The CPPE allocation of training days was supposed to be 28 days out of the 18-month period, inclusive of some days of ringfenced time for independent study. Even adding in-practice training days, the level of absence indicated by Ms Cooper could not be accounted for by the Registrant's training commitments.

k. On 5 October 2022, Colleague B contacted the Registrant by phone, and in their conversation, Colleague B said what the GP practice had said. The Registrant became defensive on the phone with Colleague B, who responded that they could discuss the matter in depth when they met in person. A meeting to discuss the matter was scheduled for 11 October 2022; on 10 October 2022, the Registrant emailed Colleague B to say she was quitting. Colleague B had no issues with the Registrant's conduct prior to the phone call on 5 October 2022. Colleague B described the Registrant as usually having a very positive disposition, but she was aggressive on the call to the extent that he asked a member of the faculty to check in with the Registrant, concerning her wellbeing, after the phone call. The

Registrant provided no reason for her resignation. The Registrant had a three-month notice period.

l. Colleague B asked another pharmacist at the Trust, Ms 1, to do a wellbeing check on her straight after the call on 5 October 2022. Colleague B aware that the Registrant went through a personal situation in September 2022 and took about three weeks off; her behaviour at this time seemed defensive, closed off, and out of character.

m. The Registrant did not attend the meeting on 11 October 2022. Despite being in work, she did not respond to any calls or messages. Colleague B spoke to the Registrant on 12 October and she agreed to attend a rescheduled meeting; this was an outgoing call by Colleague B. Colleague B would always try the Registrant's work phone as a default option, followed by her private phone if he was unsuccessful in contacting her through her work phone. Colleague B rescheduled the meeting as a call on 20 October 2022; however, the Registrant contacted Colleague B via email to say that she was sick and would not be attending.

n. A meeting was never held, and the Registrant remained on sick leave until the end of her notice period. Following this, Colleague B coordinated with the GP practice to identify which the dates the Registrant had been absent, and with CPPE to obtain more information about the Registrant's training schedule.

o. The Education Supervisor, CPPE, provided Colleague B with a list of dates where she identified discrepancies, annotated the dates in green, the dates the Registrant attended for CPPE training. From the dates there are a number of discrepancies which have been exhibited. The dates in black are the dates of study that the Trust was aware; the dates in green are further dates of study which were provided by the CPPR provider. Blank dates are where the Registrant's whereabouts were unknown. On the CPPE, there are study days and own study days (which the Registrant was entitled to take, but there were no official study sessions on those days). Colleague B would expect the Registrant to inform the surgery of all the days when she was studying.

p. Colleague B identified that the Registrant's absence was unexplained for all or part of the day on 76 dates in the period from 21 September 2021 to 12 October 2022. For 20 of these, the Registrant had advised that she was undertaking CPPE training; the CPPE had informed Colleague B that either no training was held on these dates, or the training hours were less than the surgery was advised by the Registrant.

q. In particular, Colleague B notes the following two dates. The first is 17 August 2022, when the Registrant requested 2 hours off for training; however, training was only scheduled for 1 hour and the Registrant did not attend the session. The second is 7 September 2022 – the Registrant requested this as a full day off, yet the training was only scheduled from 1pm.

r. A copy of the emails from the Registrant to her GP practice in which she requests these dates off for CPPE training are exhibited**.**

s. Additionally, the Registrant claimed that there was CPPE day at surgery on 26 January 2022. CPPE has said that there was not. The Registrant also claimed that there was a CPPE day at surgery on 28 January 2022. CPPE has said that there was not.

t. In addition to the dates where the Registrant claimed that she had out-of-practice training commitments, there are a number of dates where the Registrant had no appointments or work in her calendar, indicating that she may not have been in the office. In a busy GP environment, it is unlikely that the Registrant would have had no work to do if she had been in the office. Colleague B asked that GP surgeries to record work carried out as appointments, so that Colleague B can track pharmacist workloads and ensure that they remain manageable.

u. Although Colleague B obtained information from CPPE about the training commitments on record for the Registrant, they can only account for days with directed lectures or sessions, not for any independent work time learners have taken (altogether, this expected to amount to about 19.5 days over this period) In total the course is 28 study days over the 18 months. The 28 days includes all lectures/seminars/residentials/taught sessions and independent study time.

v. Colleague B had concerns about the Registrant's conduct in respect of her being very defensive when the subject of her attendance was broached on the phone, followed by her handing in her notice. Colleague B describes the Registrant as someone who did not want to talk about her absences; her tone changed and her answers became "*yes/no*".

w. When the Registrant went off sick, she became uncontactable. In a subsequent email dated 31 October 2022, the Registrant claimed the reason for this was that her personal and work phone was damaged by a water leak at RMC and that she was waiting for them to get fixed. Colleague B contacted RMC the same day to obtain further information about this incident, and the Practice Manager advised Colleague B that same afternoon that no such incident had taken place to their knowledge.

x. Colleague B was made aware of issues with the Registrant's clinical work by Ms 1 during a 1 to 1. Ms 1 informed Mr 1 she was completing Advanced Practitioner course in pharmacy. As part of her dissertation, Ms 1 was analysing the clinical work of two pharmacists. Ms 1 mentioned to Colleague B that she cannot use the data from the Registrant's work, because she was not doing the things she should be doing such as monitoring and following up patients after the medication review.

y. The Trust does clinical training for pharmacists in-house, including an open-floor case review every two weeks. Plenty of training is provided to staff. The Registrant was provided with a 3-week induction when she commenced her contract. Along with all the Trust mandatory training and corporate induction, she also shadowed several pharmacists carrying out their daily duties including SMRs.

z. If the Registrant's GP practice had concerns about her clinical work, these would have brought to Colleague B and the Trust. The GP practice has a history of being candid with us about any issues or concerns. If the Registrant did not attend work, Colleague B would expect a phone call from the GP practice straight away. The GP practice did not raise any concerns in relation to the Registrant's clinical practice.

aa. Colleague B was concerned that the Registrant was not getting sufficient supervision from the GP practice and had to interject.

bb. Colleague B asked Ms 1 if the Registrant's work at the Trust looked like it had begun correctly when she joined. Ms 1 said that it appeared that it had started right, but that the quality of the work had deteriorated over time. Ms 1 said that she might contact the CPPE tutor who had been in touch with her previously. Colleague B felt it would be difficult to take further steps on this matter as the Registrant was no longer employed by the Trust.

cc. Colleague B said that Candesartan and Ramipril should never be prescribed together.

Decision on Facts

27. The Registrant did not attend and therefore all allegations were considered by the Committee to be denied. When considering each particular of allegation, the Committee bore in mind that the burden of proof rests on the Council and that particulars are found proved based on the balance of probabilities. This means that particulars will be proved if the committee is satisfied that what is alleged is more likely than not to have happened.

28. 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.

29. At the outset, the Committee noted that it found the evidence of Ms 1, Ms 2, Colleague C, Mr 1, and Colleague B to be consistent and credible.

<u>Allegation 1 – On or before 2 February 2023, the Registrant submitted two CPPE clinical assessments which had not been completed under the supervision of a clinical mentor or clinical supervisor</u>

30. Ms 2 provided evidence that on 2 February 2023, the Registrant submitted her completed SOAP documents, including two Case-based Discussion forms (CbD1 and CbD2) and two Medicines Related Consultation Assessment Tool records (MR-CAT1 and MR-CAT2). The Committee has had sight of the following documents:

a. A CbD dated 25 March 2022 signed by assessor "Lianne Clarke".

b. A CbD dated 25 March 2022 signed by assessor "Julie Cox".

c. A CbD dated 11 October 2022 signed by assessor "S Shah".

d. MR-CAT1 dated 10 November 2022 and is purportedly assessed by "Colleague A".

e. MR-CAT2 dated 14 November 2022 and is purportedly assessed by "Colleague A".

Consequently, the Committee considers that on or before 2 February 2023, the Registrant submitted two CPPE clinical assessments.

31. In her witness statement, Ms 2 said that "Lianne Whitehead" was listed as the Registrant's Clinical Mentor. One of the CbD forms names the assessor as "Lianne Clarke". In her oral evidence, Ms 2 confirmed that "Lianne Whitehead" and "Lianne Clark" are the same person. Ms 2 further explained that Lianne Clark is a pharmacy technician and is not eligible to be a Clinical Mentor that would assess a Case based Discussion. Ms 2 confirmed that Clinical mentors, rather than clinical supervisors, would assess CbDs.

32. In her witness statement, Ms 2 said that "L Panray" was listed as the Registrant's Clinical Mentor in the other CbD. However, there is no CbD form before the Committee assessed by "L Panray".

33. The Committee has seen an email from Colleague A to Ms 2 dated 8 February 2023 setting out that it is not his handwriting on MR-CAT1 or MR-CAT2. Ms 2 provided evidence that Colleague A was the Clinical Supervisor of the Registrant. It is not known by the Committee, under whom, if anyone, the Registrant completed the MR-CATs.

34. In an undated reflective piece, the Registrant admits to filling out the MR-CAT forms and getting a locum GP to sign them. It does not appear, even on the Registrant's own admission, that the locum GP conducted an assessment of the Registrant:

> "*During module 4, my clinical supervisor was uncontactable and unreachable, and I tried on numerous attempts to contact them by phone and email unsuccessfully. I however was able to finally reach them, and we arranged a date to perform assessments outlined in MR-CAT. They however did not turn up for assessment date and when I tried to reach them, I realised that I needed to look for an alternative to person to complete my MR-CAT assessments with. As there were no permanent GP'S working at the surgery at this time, I ended up asking a locum GP that was working also at the surgery to complete the assessment for me. Due to time pressures, he asked me to fill in the paperwork and he signed it, and I forgot to change the name of the Clinician to the locum clinician, and this was a regrettable over-site on my part and upon reflection I realise how unprofessional this was and would like to offer my sincere apologies to this misconduct which I deeply regret doing and demonstrated lack of insight.*"

35. Although Colleague C provides minutes of a phone meeting between herself and the Registrant which took place on 4 April 2023, reference is solely made to "paperwork"

and the Committee cannot be certain which "paperwork" is being referred to in these minutes: "*PG asked SS what her thoughts were now regarding the situation and SS said that shouldn't have submitted the paperwork and should just have said she couldn't find it. SS said that she can see how it comes across and maybe it was the pressure of submitting the documents. SS said it's not something she has done before and not something she is proud of.*"

36. Given the evidence set out above, the Committee considers that, on a balance of probabilities, the Registrant's actions proved at allegation 1 for documents CbD1, MR-CAT1 and MR-CAT2, however, not CbD2.

This particular is found proved.

Allegation 1.1 – The two case-based discussion assessments the Registrant submitted to CPPE (CbD1 and CbD2) were different from those on record with the clinical mentors who undertook those assessments with you

37. Ms 2 provided evidence that on 2 February 2023, the Registrant submitted her completed SOAP documents, including two Case-based Discussion forms (CbD1 and CbD2).

38. The Committee has had sight of a CbD form assessed by "S Shah" dated 11 October 2022. The section completed by the learner is identical to that assessed by Lianne Clark dated 25 March 2022. However, Section 2, which is to be completed by the assessor is different. Ms 2 provided evidence that she obtained the CbD form directly from the assessors, who are the clinical mentors, after emailing them.

39. In her undated reflective piece, the Registrant admits fabricating both sets of CbD forms: "*during submission of both sets of Case based discussion forms, I do admit that I fabricated the forms and deeply regret my actions and realise how this is unacceptable behaviour and am thoroughly sorry I behaved in this manner.*"

40. Given the evidence set out above, the Committee considers that, on a balance of probabilities, the Registrant submitted to CPPE both CbD forms which were different from that on record with the clinical mentors with whom undertook the assessment with the Registrant.

This particular is found proved.

Allegation 1.2 – The clinical supervisor the Registrant listed on her two MR-CAT assessments, Colleague A, did not complete those assessments with her

41. Ms 2 provided evidence that Colleague A had not been involved with the Registrant's MR-CAT assessments. The Committee considers this evidence to be hearsay evidence, but considers it admissible as:

a. It is supported by an email from Colleague A to Ms 2 dated 8 February 2023 setting out that it is not his handwriting on MR-CAT1 or MR-CAT2;

b. It is further supported by the Registrant's admissions in her undated reflective piece set out at paragraph 34 above; and

c. The Committee has not found any reason for Colleague A or Ms 2 to fabricate their evidence.

42. Given the evidence set out above, the Committee considers that, on a balance of probabilities, Colleague A did not complete the two MR-CAT assessments with the Registrant.

This particular is found proved.

Allegation 2.1 – The Registrant's actions in allegation 1 were dishonest in that she knew that the two-based discussion assessments she submitted to CPPE (CbD1 and CbD2) were different from those on record with the clinical mentors who undertook those assessments with her

43. 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.*"

44. The Committee considered that the Registrant was dishonest in that she knew that both CbD forms that she submitted were different from those on record with the clinical mentors for the following reasons:

a. In her undated reflective piece, the Registrant admits fabricating the CbD forms: "*during submission of both sets of Case based discussion forms, I do admit that I fabricated the forms and deeply regret my actions and realise how this is unacceptable behaviour and am thoroughly sorry I behaved in this manner.*"

b. She had motivation to do so, as she said in her undated reflective piece, that the "*submission date was approaching*".

45. The Committee considered that the Registrant knew that she submitted fabricated CbD documents, which were different from those on record with her clinical mentors.

The Committee considered this action to be dishonest by the standards of ordinary decent people.

This particular is found proved.

Allegation 2.2 – The Registrant's actions in allegation 1 were dishonest in that she knew that the clinical supervisor she listed on her two MR-CAT assessments, Colleague A, did not complete those assessments with her

46. The Committee considered that the Registrant was dishonest in that she knew that the clinical supervisor she listed on her two MR-CAT assessments, Colleague A, did not complete those assessments with her, for the following reasons:

    a. In her undated reflective piece, the Registrant admits using a clinical supervisor who was not Colleague A: "*I ended up asking a locum GP that was working also at the surgery to complete the assessment for me.*"

    b. She had motivation to do so, as she said in her undated reflective piece, that this was "*due to time pressures*".

    c. Although the Registrant has said that she "*forgot to change the name of the Clinician to the locum Clinician*" she still knew that Colleague A did not complete the MR-CATs assessments with her and made no attempt at any point to correct the MR-CAT forms.

47. The Committee considered that the Registrant knew that Colleague A did not complete the MR-CATs assessments with her, but still submitted them. The Committee considered this action to be dishonest by the standards of ordinary decent people.

This particular is found proved.

Allegations 3 and 3.1 – During the Registrant's employment with The Northamptonshire Health NHS Foundation Trust, she provided incorrect reasons as to why she was uncontactable during a period of sick leave in that she informed Colleague B on 31 October 2022 that it was due to her personal and work phone being damaged by a water leak at Rushden Medical Centre

48. The Committee has seen an email from the Registrant to Colleague B, dated 31 October 2022, in which she says: "*Please find attached my sick note for the next 2 weeks. Both my work phone and personal phone got water damage due to water leak at RMC pipe into my bag and am waiting to fix them.*"

49. The Committee has seen an email from Colleague B to the Operations Manager at the Rushden Medical Centre, dated 31 October 2022, in which he asks: "*May I please check if there had been a water leak at [Rushden Medical Centre] on w/c 17/10/22 and did [the Registrant] mention if any of her belongings had become damaged as a result of*

this leak?" The Operations Manager at the Rushden Medical Centre responded approximately 1.5 hours later with "*Not that I'm aware of?*".

50. Colleague B's evidence reflected these emails.

51. The Committee considered there to be no water leak at the Rushden Medical Centre given the unawareness of this by the Rushden Medical Centre Operations Manager and the lack of correspondence from the Registrant to the Trust to get her work phone fixed. It would be incumbent on the Registrant's workplace to fix a phone which got damaged as a result of a workplace incident (e.g. a water leak on work premises).

52. Further, despite communications 10 October 2022, 12 October 2022 (which included an outgoing call from Colleague B to the Registrant's work phone or personal phone), and an email on 30 October 2022 from the Registrant to Colleague B, she failed to mention the damage to her work or personal phones. The Committee does not consider the lack of action from the Registrant to align with damage having being done to her work and personal phone.

53. Consequently, the Committee considers that, on a balance of probabilities, the Registrant provided incorrect reasons on 31 October 2022 as to why she was uncontactable during a period of sick leave.

This particular is found proved.

<u>Allegation 4.1 – The Registrant's knew that her actions in allegations 3 and 3.1 were dishonest in that she knew that the explanation provided was untrue</u>

54. The Committee considered that the Registrant knew her explanation provided that her "*work phone and personal phone got water damage due to water leak at RMC pipe into my bag and am waiting to fix them*" was untrue given the reasons set out in paragraphs 51 and 52, namely that the Committee considers that, on a balance of probabilities, there was no water leak. And even if there was a water leak, on a balance of probabilities, the Registrant's actions do not align with a water leak having taken place which damaged both her work and personal phone. The Committee considered the action of the registrant in providing an explanation that her "*work phone and personal phone got water damage due to water leak at RMC pipe into my bag and am waiting to fix them*" to be dishonest by the standards of ordinary decent people.

This particular is found proved.

<u>Allegation 4.2 – The Registrant's knew that her actions in allegations 3 and 3.1 were dishonest in that she intended to mislead Colleague B</u>

55. Colleague B said that he contacted the Registrant by phone on 5 October 2022 concerning her attendance. In this conversation, Colleague B said that the Registrant became defensive and aggressive, and although Colleague B spoke to the Registrant

on 12 October 2022, the Registrant emailed Colleague B on 10 October 2022 to say that she was quitting, and did not attend meetings scheduled for 11 October 2022 and 20 October 2022. The Committee considered that from 5 October 2022, the Registrant demonstrated behaviour which was seeking to avoid Colleague B. Being dishonest that her work and personal phones were damaged would be in keeping with the Registrant's attempts to avoid Colleague B.

56. Consequently, the Committee considers that, on a balance of probabilities, the Registrant knew that her actions in allegations 3 and 3.1 were dishonest in that she intended to mislead Colleague B, by avoiding him.

This particular is found proved.

Allegations 5 and 5.1 – In an end of probation meeting with Colleague C on 18 April 2023, the Registrant provided inaccurate information in that she stated that her last day working for The Northamptonshire Health NHS Foundation Trust was 07 April 2023

57. The Committee has seen minutes of an end of probation meeting between the Registrant and Colleague C. In these minutes, the Registrant states that she was doing locum work for her previous GP practice. This would have been the practice to which she was sent to work by the Trust.

58. The minutes state that "*[Colleague C] asked the date when [the Registrant] last worked for [the previous GP practice] and [the Registrant] checked her calendar and said the 7th April.*" Colleague C took minutes of the 18 April 2023 end of probation meeting but these were not signed or acknowledged by the Registrant despite them being emailed to her. Colleague C confirmed that they were an accurate reflection of the meeting. In light of the Registrant having the opportunity to correct the minutes, but failing to do so, the Committee considers the minutes of the 18 April 2023 end of probation meeting to be fair and accurate.

59. Consequently, the Committee considers that, on a balance of probabilities, the Registrant provided inaccurate information in that she stated that her last day working for The Northamptonshire Health NHS Foundation Trust was 07 April 2023.

This particular is found proved.

Allegation 6.1 – The Registrant's knew that her actions in allegations 5 and 5.1 were dishonest in that she knew that she had left with The Northamptonshire Health NHS Foundation Trust on 10 January 2023, and had not worked any shifts for them since that date

60. Colleague B provided evidence that the Registrant had handed in her notice on 10 October 2022 and that she had a three-month notice period. Further, Colleague B

provided evidence that the Registrant remained on sick leave from 20 October 2022 to her final date which was 10 January 2023.

61. The Committee considers that the Registrant would have known when she handed in her resignation and the length of her notice period. She would have likely been aware that she was no longer being paid by the Trust and, consequently, would have known that her final date working with the Trust, and subsequently her previous GP practice, was on 10 January 2023. The Registrant would have known that she was not working any more shifts with her previous GP practice from 10 January 2023.

62. Consequently, on a balance of probabilities, the Registrant knew that the last day with the Trust was on 10 January 2023, and was dishonest with Colleague C when she said that she was still doing shifts with her previous GP practice. In doing so, the Registrant was dishonest by the standards of decent ordinary people.

This particular is found proved.

Allegation 6.2 – The Registrant's knew that her actions in allegations 5 and 5.1 were dishonest in that she knew intended to mislead Colleague C

63. The Committee considered that the Registrant intended to mislead Colleague C due to the background of dishonesty, which led up to the dishonest statement in this allegation. The background, according to the minutes, is as follows:

a. The Registrant had "*spoken to a GP where I am currently working and she has agreed to do MR-CAT assessment with me*".

b. When challenged by Colleague C as to which GP in her current practice (which would have been Saffron Health), the Registrant set out that "*she meant a GP at her previous practice not Saffron*".

c. In response, Colleague C said that this explanation "*case across as an inconsistency in what [the Registrant] had written and then said when asked about it*".

d. The Registrant then said "*that she still does locum shifts for her previous practice so this is why she thought of them as her current employer*".

e. When Colleague C said that she was unaware that the Registrant was doing this, and asked when the Registrant was doing these shifts, the Registrant said "*as and when shifts come up*". This is when the Registrant said that she last worked for the previous GP practice on 7 April 2023.

64. The Committee considers that Registrant intended to mislead Colleague C with the dishonesty found in allegation 6.1 due to the need to cover up a previous dishonest statement, namely that she was still working shifts at her previous pharmacy, which the Registrant said to cover up a previous dishonest statement that she is currently working with a GP who has agreed to do a MR-CAT assessment with her.

65. Given the evidence set out above, the Committee considers that, on a balance of probabilities, the Registrant knew that her actions in allegations 5 and 5.1 were dishonest in that she intended to mislead Colleague C.

This particular is found proved.

Allegation 7 – In the course of the Registrant's employment with the Primary Care Network at Northamptonshire Healthcare NHS Foundation Trust between 17 May 2021 to 10 January 2023, she reported CPPE training commitments during working hours to her workplace, Rushden Medical Centre

66. The Committee has had sight of the dates the Registrant reported CPPE training commitments to her workplace, Rushden Medical Centre. These dates are between 17 May 2021 and 10 January 2023. Therefore, the Committee finds allegation 7 to be proved.

This particular is found proved.

Allegation 7.1 – The hours the Registrant declared that she had out-of-practice training were in excess of her actual commitments

67. Colleague B provided evidence that the Registrant's absence was unexplained for all or part of the day on 76 dates in the period from 21 September 2021 to 12 October 2022. For 20 of these, the Registrant had advised that she was undertaking CPPE training; the CPPE had informed Colleague B that either no training was held on these dates, or the training hours were less than the surgery was advised by the Registrant.

68. Although Colleague B obtained information from CPPE about the training commitments on record for the Registrant, Colleague B set out that the CPPE can only account for days with directed lectures or sessions, not for any independent work time learners have taken (altogether, this expected to amount to about 19.5 days over this period) In total the course is 28 study days over the 18 months. The 28 days includes all lectures/seminars/residentials/taught sessions and independent study time.

69. Colleague B further set out that if the Registrant's GP practice had concerns about her clinical work, these would have brought to Colleague B and the Trust. The GP practice has a history of being candid with us about any issues or concerns. If the Registrant did not attend work, Colleague B would expect a phone call from the GP practice straight away. The GP practice did not raise any concerns in relation to the Registrant's clinical practice. Further, there is no evidence before the Committee that the GP practice raised any immediate issues concerning the Registrant's attendance during her time with them; no issue was raised until Colleague B asked the GP practice for records of the Registrant's attendance at the GP practice.

70. The Committee considers that the Registrant could have had the following tasks, beyond her study, which would be unlikely to have been accounted for in her diary:

a. Repeat prescription reviews;

b. Medicines reconciliation;

c. Clinical audits;

d. Managing prescription queries;

e. Repeat dispensing management;

f. Medication safety monitoring;

g. Regulatory compliance;

h. Training and support for staff;

i. Prescribing systems;

j. Monitoring Key Performance Indicators;

k. Liaison with community pharmacies;

l. Coordination with multi-disciplinary teams; and

m. Other miscellaneous tasks, including budget management, policy development, stock management, responding to patient complaints and preparation for inspections.

71. Although there are absences for part of all of 76 days, these were not all necessarily declared as out-of-practice training; many were simply unaccounted for and could fall under any of the tasks listed at paragraph 70 above. The Committee has counted 21 days which the Registrant claimed to the GP practice that she was on the CPPE, which is below the 28 days permitted. Further, there is no evidence before the Committee of the GP practice raising any absence issue prior to being asked by Colleague B.

72. Given the evidence set out above, the Committee considers that, on a balance of probabilities, the hours the Registrant declared that she had out-of-practice training were not in excess of her actual commitments.

This particular is found not proved.

<u>Allegation 7.2 – The Registrant took unauthorised absences from work on the basis of these exaggerated or non-existent commitments</u>

73. For the reasons set out at paragraphs 71 and 72 above, the Committee considers that, on a balance of probabilities, it is not proved the Registrant took unauthorised absences from work on the basis of these exaggerated or non-existent commitments.

This particular is found not proved.

Allegation 8 – The Registrant's actions in 7, 7.1 and 7.2 were dishonest in that she deliberately exaggerated the extent of her CPPE training commitments, in order to take time off from work to which she knew she was not entitled

74. Given that allegations 7.1 and 7.2 have not been proved, the Committee considers that allegation 8 is not proved.

This particular is found not proved.

Allegation 9 – On 30 March 2023, the Registrant dispensed both Ramipril and Candesartan to a service user

75. The Committee has seen minutes of an end of probation meeting between the Registrant and Colleague C in which it is stated that:

> "*[Colleague 3] then also referred to the prescribing error that had been brought to her attention in which the Registrant had prescribed both Ramipril and Candesartan in an elderly patient with poor kidney function and sensitivity to Ramipril. Dr Sharan who had become aware of this had spoken to the Registrant this morning about this and also informed [Colleague 3] of her concerns due to the basic nature of this error. [Colleague 3] said that it raised concerns about the Registrant's clinical knowledge and the Registrant replied that she does know that these 2 drugs should not be prescribed together. The Registrant explained that she had prescribed Ramipril as first line treatment but a warning had come up on the computer about sensitivity and she thought she had deleted the medication and then issued Candesartan instead. She did not realise that both drugs had been prescribed. The Registrant said that her learning point was that she should have checked on the computer that the Ramipril had been deleted properly. The Registrant acknowledged that this was a safety concern for the patient and took it seriously. [Colleague 3] noted that it was helpful to know the Registrant perspective on this.*"

76. Through this exchange, the Committee considers that the Registrant dispensed both Ramipril and Candesartan to a service user. This does not appear to be disputed by the Registrant.

This particular is found proved.

Allegation 9.1 – This service user has a documented allergy to Ramipril

77. Through the exchange set out at paragraph 75, the Committee considers that this service user has a documented allergy to Ramipril. This does not appear to be disputed by the Registrant.

This particular is found proved.

Allegation 9.2 – There is a negative pharmacodynamic interaction between Ramipril and Candesartan, and these drugs should not be prescribed together

78. Through the exchange set out at paragraph 75, the Committee considers there to be a negative pharmacodynamic interaction between Ramipril and Candesartan, and these drugs should not be prescribed together. This does not appear to be disputed by the Registrant. This was confirmed by Colleague B in his evidence.

This particular is found proved.

Allegation 10 – The Registrant failed to keep adequate records of the medication reviews set out in Schedule 1

79. Ms 1 provided evidence that during her MSc Advanced Clinical Pharmacy Practice course, she reviewed the Registrant's work, which raised concerns. Ms 1 provided evidence that it is fundamental to ask patients lifestyle questions and that structured medication reviews can have a huge impact upon lifestyle.

80. She placed these concerns into Schedule 1 which captured several factors considered relevant to the assessment of the risk and seriousness of concern. The Committee has amended Schedule 1 to cover the patients where the Registrant failed to keep adequate records of the medication reviews.

81. Given the evidence set out above, the Committee considers that, on a balance of probabilities, the Registrant failed to keep adequate records of the medication reviews set out in Schedule 1.

This particular is found proved.

Allegation 11 – The Registrant failed to request and/or undertake appropriate interventions and / or follow up actions in respect of the consultations conducted in Schedule 1

82. Ms 1 provided evidence that during her MSc Advanced Clinical Pharmacy Practice course, she reviewed the Registrant's work, which raised concerns. Ms 1 provided evidence that the Registrant: failed to order blood tests; missed blood pressure test; and missed other minimum requirements which should have been carried out. The consequences of which could have led to severe patient harm.

83. She placed these concerns into Schedule 1 which captured several factors considered relevant to the assessment of the risk and seriousness of concern. The Committee has amended Schedule 1 to cover the patients where the Registrant failed to request

and/or undertake appropriate interventions and/or follow up actions in respect of the consultations conducted.

84. Given the evidence set out above, the Committee considers that, on a balance of probabilities, the Registrant failed to request and/or undertake appropriate interventions and / or follow up actions in respect of the consultations conducted in Schedule 1.

This particular is found proved.

Submissions on Grounds and Impairment

85. Having found particulars of allegation 1, 1.1, 1.2, 2.1, 2.2, 3, 3.1, 4.1, 4.2, 5.1, 6.1, 6.2, 7, 9, 9.1, 9.2, 10, 11 proved, the Committee went on to consider whether they amounted to misconduct and, if so, whether the Registrant's fitness to practise is currently impaired.

86. In relation to the misconduct, on behalf of the Council, Ms Rawlings submitted:

a. The Registrant's particularised conduct breached the following standards of the Standards for pharmacy professionals dated May 2017:

i. Standard 1 – Pharmacy professionals must provide person-centred care (9-9.2, 10, 11);

ii. Standard 3 – Pharmacy professionals must communicate effectively (1-1.2, 3-4.2, 5-6.2);

iii. Standard 4 – Pharmacy professionals must maintain, develop and use professional knowledge and skills (9-9.2, 10, 11);

iv. Standard 6 – Pharmacy professionals must behave in a professional manner (1-2.2, 3-4.2, 5-6.2); and

v. Standard 8 – Pharmacy professionals must speak up when they have concerns or when things go wrong (3-4.2, 5-6.2).

b. The following values were not abided by:

i. Being open and communicative (1-1.2, 3-4.2, 5-6.2); and

ii. Being honest and truthful (1-2.2, 3-4.2, 5-6.2).

c. The Registrant failed to provide person-centred care and failed to properly utilise professional knowledge and skills by:

i. Missing opportunities to de-prescribe/ reduce medications for patients;

ii. Failing to ask patients sufficient lifestyle questions including e.g.: mobility, eating or drinking habits;

iii. Failing to discuss switching to alternative medications with lower risks;

iv. Failing to conduct blood tests where should have been;

v. Failing to conduct blood pressure checks where should have been;

vi. Failing to undertake pulse checks where necessary; and

vii. Made medication errors such as dispensing Ramipril and Candesartan together, to a patient with a documented allergy to Ramipril.

d. The Registrant failed to communicate effectively; speak up when things went wrong; nor did she adhere to the values of being open and communicative in the following ways:

i. Her patient-focused work at The Trust began to decline in Spring 2022 and she did not speak up to ask for additional support;

ii. Continual failure to answer the phone to professionals attempting to assist her in the face of difficulties/ issues having arisen or being suspected;

iii. Lack of engagement in meetings regarding performance; and

iv. Ignored phone, email, post communication efforts.

e. The Registrant did not behave in a professional manner and was not honest and truthful when she:

i. Refused to communicate with colleagues including superiors attempting to address issues about her conduct with her;

ii. Falsified assessment submissions;

iii. Told Colleague B a dishonest reason for being uncontactable;

iv. Lied to Colleague C about when her last day working for the Trust was during a formal probation meeting; and

v. Told Ms 1: "*this failure to engage is not how you are meant to behave as a professional*".

f. In this case we have limited insight from the Registrant:

i. She has not attended the proceedings;

ii. She has not responded to any of the Council's communications;

iii. She demonstrated a repeated pattern of refusing to engage with any manager, mentor, supervisor, or other colleague who tried to engage with her in supportive discussion and action after realising that one or more of the various issues that comprise the proven allegations had arisen. She would cease to answer calls, emails, did not turn up to several specially arranged meetings and indeed tendered her resignation to both her

employers essentially immediately upon them seeking to hold a meeting with her to see what might be going on; and

iv. Her reflective account is of very limited assistance, as it was only written when faced with a stark and fairly immediate choice of being failed or writing an excerpt such as that. It lifts word for word the prompts given as examples by Ms 2, and it is not accurate in terms of content as Ms 2 has detailed regarding the registrant's purported explanation of the signing of forms.

g. It is submitted that the panel should have regard to the following in regards to seriousness:

i. Pattern of dishonest behaviour spanning a sustained period of time, repeated to a number of different witnesses, in a variety of contexts, suggesting a real risk of repetition;

ii. Consistent pattern of dishonest behaviour shown towards a number of professionals seeking to engage with the registrant in the course of their investigations;

iii. Widespread clinical failures (allegations 10 and 11) over a period of time which created a high potential risk of harm to patients;

iv. That the Registrant denied the charges in full or part, which the panel may consider shows a lack of insight; and

v. Such behaviour as a whole is likely to undermine confidence in the profession and bring the profession into disrepute.

h. The Registrant's conduct falls far below the standards expected of a registered pharmacy professional. A finding of misconduct should be made on this basis.

87. In relation to impairment, on behalf of the Council, Ms Rawlings submitted that due to the seriousness and wide-ranging nature of the allegations, and all four grounds of Rule 5 being engaged, a finding of current impairment is required to uphold professional standards, protect the public and maintain public confidence in the pharmacy profession:

<u>Actual or potential risk to patients or to the public</u>

a. The serious dispensing error in allegation 9 risked serious patient harm for two reasons: 1) prescribing a drug a patient had a documented allergy to; 2) prescribing two drugs together which should not be prescribed together.

b. The volume and frequency of failings as part of allegations 10 and 11 risked harm including most serious patient harm (as per the evidence of Ms 1): electrolyte imbalances; arrythmias; kidney damage; strokes; heart attacks.

c. Potential risk of harm to patients as a result of the misconduct – "*we were lucky in the sense that nothing happened to these patients*" (Ms 1).

Has brought, or might bring, the profession of pharmacy into disrepute

d. Allegations 1-2.2 inclusive – This action and lack of integrity is capable of bringing the profession into disrepute as it is capable of enabling the Registrant to improperly hold a qualification that her profession would take into account as part of her professional practice.

e. Due to the pattern of dishonest behaviour which was carried out of a sustained period of time of over a year, repeated to a number of different witnesses in a variety of contexts, coupled with not taking responsibility, a complete lack of engagement, lack of remorse and no willingness to make amends, the profession may be brought into disrepute if no finding of current impairment is made.

f. A professional where honesty and integrity is particularly important. As Colleague C said during meeting with Registrant: "*accuracy and correct meaning of documentation is essential and as a practice we need to be able to trust what is being written is correct*".

Has breached one of the fundamental principles of the profession of pharmacy

g. As per paragraph 86(a)-(e) above.

Registrant's integrity can no longer be relied upon

h. There is wide-ranging dishonesty over a sustained period (at least 31 October 2022 to 18 April 2023), and as set out in:

    i. Allegations 1-2.2.

    ii. Allegations 3-4.2 inclusive.

    iii. Allegations 5-6.2 inclusive.

i. The Registrant has shown limited insight in respect of her conduct. There is a single reflective statement which appears to make some admissions to the fabrication of paperwork as part of her course submission and to express remorse. However, Ms 2's evidence highlighted some of the difficulties with the reflection – for example the explanation regarding locums is not accurate as a locum would not be someone capable of signing such a form. She said she is concerned that it shows remorse within the wording but is at odds within the content. In my submission it is not reliable as a genuine document. You may consider it appears to follow the prompt questions provided to her – with a choice of follow these or be failed – and yet does not provide a true and genuine explanation/ apology as to what actually happened. Her request to be given a chance to make amends is also, in my submission, at odds with her complete disengagement.

j. Concerning comments by Registrant during meeting with Colleague C on 4 May 2023, "*[The Registrant] thought it would be fine*" and "*didn't see it as falsifying documents*".

k. Dishonesty regarding not receiving communications the Registrant had received, and when she was challenged on things, her account often immediately changed to a different lie.

Cohen Test – whether the conduct is remediable

l. Given the fact that the allegations proven span a period of some 14 months which lend support to the misconduct being likely to be repeated. The variety of types of misconduct encompassed within the allegations proven indicates further risk of repetition.

m. These factors coupled with the Registrant's distinct lack of remediation efforts does not provide any reassurance that the conduct is remediable or unlikely to be repeated.

n. Indeed, the Registrant displayed a consistent pattern of dishonest behaviour towards a number of professionals seeking to engage with her in the course of their investigations. Ms 2's first hand assessment of the registrant was that she "*showed no remorse, did not care and seemed bored*". Colleague B described her as "*very defensive*" during a phone call after which she handed in her notice. Ms 1 stated that the Registrant: "*wouldn't communicate with us*". Colleague B said about the Registrant in a meeting to discuss concerns about her that had been raised she "*seemed bored and almost flippant*", "*I formed the impression there was no remorse for her conduct*", and "*she did not seem to care about its implications*".

o. Another potentially relevant factor is the Registrant's denial, in whole or part, of the allegations. Maintaining a denial cannot of course be grounds for impairment in and of itself. But on balance, the panel may conclude there is wholly limited evidence of insight as a result of denial and non-attendance at the proceedings.

p. The Registrant has failed to engage with the Council investigation and has neither demonstrated insight nor remorse nor submitted any explanation to the Council for her behaviour and failings.

88. The Registrant did not attend to give evidence or provide oral submissions in relation to misconduct and impairment. The Registrant did not provide written submissions on misconduct or impairment for the Committee to take into consideration.

Decision on Grounds

89. 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).

90. 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.*"

91. 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.*"

92. The Committee accepts the Registrant's explanation for her actions at allegation 9, which was provided in the Registrant's End of Probation Meeting on 18 April 2023 with Colleague C:

> "*[The Registrant] explained that she had prescribed Ramipril as first line treatment but a warning had come up on the computer about sensitivity and she thought she had deleted the medication and then issued Candesartan instead. She did not realise that both drugs had been prescribed. [The Registrant] said that her learning point was that she should have checked on the computer that the Ramipril had been deleted properly. [The Registrant] acknowledged that this was a safety concern for the patient and took it seriously.*"

93. There is no other evidence to the contrary before the Committee. The Committee considered the Registrant's explanation to be plausible and that she demonstrated a learning point. Consequently, the Committee does not consider the Registrant's actions at allegation 9 amount to misconduct.

94. The Committee considered that Registrant's actions, excluding allegation 9, reached the threshold of misconduct as she:

a. Has demonstrated a pattern of dishonesty spanning a sustained period of time of over a year to a number of different people in a variety of different contexts;

b. Failed to properly care for patients, in that she failed to fully assess patients or carry out the correct checks (blood pressure, blood tests, etc) and ask pertinent lifestyle questions, which could have altered the medication which the patient was on;

c. Failed to communicate effectively, in that there was a lack of engagement in meetings concerning her performance and she ignored communications from her employers.

95. 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)*).

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

a. Standard 1 – Pharmacy professionals must provide person-centred care, and Standard 4 – Pharmacy professionals must maintain, develop and use professional knowledge and skills. In particular, the Registrant:

i. Failed to ask patients sufficient lifestyle questions;

ii. Failed to conduct minimum checks, including blood tests, blood pressure and pulse checks;

iii. Failed to discuss switching to alternative medication; and

iv. Consequently, missed opportunities to reduce medication or switch to medication with lower risks.

b. Standard 3 – Pharmacy professionals must communicate effectively. In particular, the Registrant:

i. Lacked engagement in meetings regarding performance; and

ii. Ignored phone, email and postal communications with fellow professionals who were attempting to assist the Registrant with her practice.

c. Standard 6 – Pharmacy professionals must behave in a professional manner, and Standard 8 – Pharmacy professionals must speak up when they have concerns or when things go wrong. In particular, the Registrant:

i. Refused to communicate with colleagues including superiors attempting to address issues about her conduct with her;

ii. Falsified assessment submissions;

iii. Told Colleague B a dishonest reason for being uncontactable; and

iv. Lied to Colleague C about when her last day working for the Trust was during a formal probation meeting.

97. The Committee bore in mind that the Standards may be taken into account when considering the issues of grounds and impairment but that a breach of the Standards does not automatically establish that the Registrant's fitness to practise is impaired (Rule 24(11)).

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

Decision on Impairment

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

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

101. The Committee considers that the Registrant has limited insight and remorse. Although the Registrant submitted a reflective account, it provides limited evidence to demonstrate insight and remorse given it was written under a threat of being failed for the CPPE. However, the Committee considered that the reflective piece sets out the following insight and remorse, in that the Registrant:

a. admits the fabrication of the CbD forms and MR-CAT assessments;

b. expresses remorse for fabricating the documents;

c. demonstrates her understanding of Standards that she has breached; and

d. acknowledges that this broke trust in her professionalism.

102. However, there is a lack of further insight and remorse given the Registrant:

a. has demonstrated a repeated pattern of refusing to engage with any manager, mentor, supervisor, or other colleague who tried to engage with her to assist in her career;

b. ceased to answer calls, emails, did not turn up to several specially arranged meetings and tendered her resignation to both her employers immediately upon being asked for an explanation of her conduct as outlined in the allegations;

c. has not attended the proceedings; and

d. has not responded to any of the Council's communications.

103. The Committee considered that the Registrant has not completed any remediation.

104. 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.

<u>Whether the Registrant's conduct or behaviour presents an actual or potential risk to patients or to the public</u>

105. The Committee considers that the Registrant's conduct and behaviour presented an actual risk of harm to patients given the volume and frequency of failings as part of allegations 10 and 11, risked harm to patients, including electrolyte imbalances; arrythmias; kidney damage; strokes; heart attacks.

106. Given the limited insight and remorse, and lack of remediation completed by the Registrant, as set out in paragraphs 101-103 above, 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 has brought, or might bring, the profession of Pharmacy into disrepute

107. The Committee considered that the Registrant's misconduct has brought the profession of pharmacy into disrepute on the basis that she:

a. Has demonstrated a pattern of dishonest behaviour which was carried out over a sustained period of time of over a year, repeated to a number of different people in a variety of contexts; and

b. lacked professional engagement.

108. Given the limited insight and remorse, and lack of remediation completed by the Registrant, as set out in paragraphs 101-103 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 has breached one of the fundamental principles of the profession of Pharmacy

109. The Committee considered that the Registrant's conduct and behaviour has breached more than one of the fundamental principles of the profession of pharmacy, namely the requirements to act with honesty and integrity and provide adequate care.

110. Given the limited insight and remorse, and lack of remediation completed by the Registrant, as set out in paragraphs 101-103 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 shows that the integrity of the Registrant can no longer be relied upon

111. The Committee considers that the integrity of the Registrant can no longer be relied upon given there is wide-ranging dishonesty over a sustained period (at least 31 October 2022 to 18 April 2023) which has been found in the proven allegations.

112. Given the limited insight and remorse, and lack of remediation completed by the Registrant, as set out in paragraphs 101-103 above, the Committee considers that the Registrant's continued behaviour shows that her integrity can no longer be relied upon.

Committee's conclusion on impairment

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

114. Further, members of the public would be appalled to learn that a pharmacist had conducted the actions set out in the proven allegations. 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

115. 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.

116. 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.

117. 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.

118. On behalf of the Council, Ms Rawlings submitted:

a. The mitigating factor in this matter is that, whilst not formal admissions for the sake of these proceedings, the Registrant provided an explanation for her actions at allegation 9 and made some admissions to the fabrication of CbD and MR-CATs assessments.

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

i. A pattern of dishonesty spanning a sustained period over a few months;

ii. Dishonesty to a number of different people, including professionals, in a variety of contexts;

iii. Failure to engage with attempts by employers to assist/ intervene regarding her performance/ misconduct;

iv. The risk for patient harm was high in this case as a result of failing to properly care for patients;

v. Failure to attend the proceedings;

vi. Failure to respond to any of the Council's communications; and

vii. Denial of the allegations in full or part.

c. Removal is the appropriate sanction bid, for the following reasons:

i. The integrity of the registrant can no longer be relied upon;

ii. There is a significant risk posed to the public;

iii. It is necessary to highlight to the profession and the public that the conduct of the registrant is unacceptable and unbefitting of a member of the pharmacy profession;

iv. Public confidence in the profession demands no lesser outcome;

v. To maintain proper standards of behaviour;

vi. There is a severe risk of repetition of misconduct; and

vii. The period of time over which the misconduct occurred.

d. Integrity is a paramount value of the profession. The finding that the integrity of the Registrant can no longer be relied upon is in and of itself a reason why removal is the most appropriate sanction bid. If the Registrant were to return to work, no conditions could usefully mitigate the risk of harm to patients as a result of her integrity being unable to be relied upon. No suitable conditions could be put in place that could be practical, monitored and assessed.

e. There is a significant risk posed to the public if the Registrant were allowed to continue to practice based on the failure to properly treat patients and the high risk of harm that this caused for numerous patients.

f. Given the limited insight and remorse, and lack of remediation completed by the Registrant, the Registrant's misconduct may be repeated, which presents an ongoing actual or potential risk to patients or to the public. Crucially, she has not agreed to abide by any conditions.

g. The Registrant's limited insight, lack of acknowledgment and associated risks is also capable of bringing the profession of pharmacy into disrepute in the future.

h. Removal is necessary to maintain public confidence in the profession in light of the fact that the registrant's misconduct has brought the profession of pharmacy into disrepute by:

i. demonstrating a pattern of dishonest behaviour which was carried out over a sustained period of time of over a year, repeated to a number of different people in a variety of contexts; and

ii. lacking professional engagement.

i. The serious nature of the allegations proven, specifically the dishonesty, suggests that public confidence in the sector would be undermined should the registrant be permitted to remain on the register.

j. Further, the extended timeframe over which the misconduct occurs weighs against the imposition of a suspension.

k. Finally, as the Registrant has been found to have breached five of the nine fundamental principles of the profession of pharmacy standards of behaviour, there is a real and evidenced risk that the Registrant may breach one or more of these in the future.

119. The Registrant did not attend to give evidence or provide oral submissions in relation to sanction. The Registrant did not provide written submissions on sanction for the Committee to take into consideration.

120. The Committee agreed with the mitigating factors set out by Ms Rawlings at paragraph 118 above, and also considered the Registrant's previous history of no regulatory problems to be mitigating. The Committee considered the following to be aggravating factors:

a. A pattern of dishonesty spanning a sustained period of time of over a few months;

b. Dishonesty to a number of different people, including professionals, in a variety of contexts;

c. Failure to engage with attempts by employers to assist/ intervene regarding her performance/ misconduct. To the Committee, it appeared that the Registrant avoided any such engagement, instead choosing to leave employments prior to any such engagement becoming possible; and

d. The risk for patient harm was high in this case as a result of failing to properly care for patients.

121. The Committee considers that the Registrant's proven misconduct, coupled with limited insight and remorse, 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.

122. The Committee next considered the imposition of conditions of registration on the Registrant. The Committee did not consider that conditions would be appropriate given:

a. The multiple findings of dishonesty, for which only serious sanctions are appropriate;

b. Dishonesty is attitudinal in nature, making the formulation of conditions very difficult; and

c. no relevant or proportionate conditions could be formulated, or enforced, to mitigate risk from the Registrant repeating her misconduct, given her limited insight and remorse, 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.

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

> "*The committee considers that a warning or conditions are not sufficient to deal with any risk to patient safety or to protect the public, or would undermine public confidence.*
>
> *When it is necessary to highlight to the profession and the public that the conduct of the professional is unacceptable and unbefitting a member of the pharmacy profession. Also when public confidence in the profession demands no lesser outcome."*

124. The Committee gave serious consideration to a suspension given her good start to her employment at the Trust. However, her performance deteriorated rapidly without signs of improvement. For the following reasons, the Committee considered that a suspension is not an appropriate and proportionate sanction as:

a. The Council's Guidance sets out: "*The GPhC believes that dishonesty damages public confidence, and undermines the integrity of pharmacy professionals*." The Committee has found multiple occasions of dishonesty in the proven allegations, spanning a sustained period of time of over a year. On at least one occasion, the dishonesty was to cover up previous dishonest statements. Multiple occasions of dishonesty by a pharmacist will severely damage public confidence.

b. The Guidance sets out: "*Some acts of dishonesty are so serious that the committee should consider removal as the only proportionate and appropriate outcome. This includes cases that involve intentionally defrauding the NHS or an employer, falsifying patient records, or dishonesty in clinical drug trials.*" The MR-CATs were not written by Colleague A, but as admitted, the Registrant herself for an unidentified locum GP to sign. The Committee considers this to be a premeditated dishonesty of falsifying assessments which are crucial to the educational achievements of a pharmacist.

c. The Guidance sets out: "*Acting with openness and honesty when things go wrong is an essential duty for all pharmacy professionals. Our published standards say professionals must be candid and honest when things go wrong.*" The Guidance

further sets out: "*the GPhC's view is that committees should take very seriously a finding that a pharmacy professional took deliberate steps to avoid being candid with a patient, or with anyone involved in a patient's care […] It should consider outcomes at the upper end of the scale when dealing with cases of this nature.*" The actions of the Registrant seem to follow a pattern that when more light is shed on her conduct and behaviour, the more she attempts to escape it, having left two employments to avoid a critique of her conduct and behaviour. The Registrant's actions are antithesis to acting openly and with candour.

d. The Registrant has limited insight and remorse, which was provided under duress of her failing the CPPE. She has completed no remediation and, given her lack of interaction with these proceedings, has given little indication that she is willing to remediate her conduct over time.

e. The Registrant has had over 18-months to provide an explanation for her actions; this has not been forthcoming despite numerous occasions for an explanation to be given.

f. A suspension would not instil public confidence in the profession as it would not adequately protect the public, sufficiently uphold public confidence, and maintain professional standards in someone who has shown no signs in willing to engage in improving her practice.

g. The risk for patient harm was high in this case as a result of failing to properly care for patients, and it was only due to luck that a patient was not injured.

125. The Committee therefore directs that the Registrant be removed from the Council's Register.

Decision on Interim Measure

126. The Committee took account of the fact that its decision to remove the Registrant from the Council register will not take effect until 28 days after the Registrant is formally notified of the outcome, or until any appeal is concluded.

127. The Committee has found that there remains a risk that the Registrant might repeat her conduct, if permitted to return to work unrestricted. For the reasons set out in this decision, the Registrant's unrestricted registration would place patients 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.

128. 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.

129. 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.

130. This concludes the determination.