General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote videolink hearing

27 January 2025 to 4 February 2025

Registrant name:	Mohammed Habib
Registration number:	2071490
Part of the register:	Pharmacist
Type of Case:	Misconduct

Committee Members:

Chair	Andrew Lewis
Registrant member	Cristian Ioanas
Lay member	Paul Barton

Committee Secretary:	Zainab Mohamad

Registrant:	Present and represented by Penny Maudsley, counsel
General Pharmaceutical Council:	Represented by Tom Hoskins, counsel

Facts proved:	
Facts proved by admission:	All
Fitness to practise:	Impaired
Outcome:	Suspension for 12 months with review
Interim measures:	Interim suspension imposed

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 5 March 2025 or, if an appeal is lodged, once that appeal has been concluded. However, the interim suspension set out in the decision takes effect immediately and will lapse when the decision takes effect or once any appeal is concluded.

Particulars of Allegation (as amended)

You, a registered Pharmacist, during the course of your engagement as a Pharmacist Independent Prescriber and, between approximately July 2020 to September 2021 as Clinical Lead, with UK Meds Direct Limited ("UK Meds"):

1. On or around, 5 November 2019 and 7 July 2022, prescribed medicines on 62,689 occasions using an online questionnaire based prescribing model.

2. On or around5 November 2019 and 7 July 2022, prescribed high-risk medicines on 4,859 occasions using an online questionnaire based prescribing model.

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

3.1 failed to obtain adequate information in relation to the patients' health in advance of prescribing;

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

3.3 failed to access and/or attempt to access patients' General Practitioner ("GP") medical records and/or specialist clinic records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

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

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

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

3.7 failed to put adequate safety-netting in place.

4. On or around, 5 November 2019 and 6 October 2020, you prescribed in circumstances where UK Meds' prescribing model or service was incapable of supporting safe prescribing decision in that:

4.1 no face-to-face consultation took place other than the use of an online questionnaire;

4.2 patients provided information primarily through an online questionnaire and/or;

4.3 the questionnaire at 4.2 above could be easily manipulated by patients as it notified them of answers which could prevent the supply of the medication they desired and permit the patient to change their answer.

5. On or around, 7 October 2020 and 7 July 2022, you prescribed in circumstances where UK Meds' prescribing model or service was incapable of supporting safe prescribing decision in that:

5.1 no face-to-face consultation took place other than the use of an online questionnaire and/or;

5.2 patients provided information primarily through an online questionnaire.

6. In relation to 1 and/or 2 above, you prescribed a significant portion of prescriptions in circumstances where the time taken would not have been sufficient for you to clinically evaluate the suitability of the medicines to the patient including to:

6.1 read, consider and assimilate the completed online questionnaire;

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

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

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

6.5 consider the steps you ought to take to prescribe in accordance with UK prescribing guidance as set out at 3 above.

7. On 10 May 2020, prescribed 28 tablets of propranolol 10mg to Patient 13 in circumstances where you:

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

7.2 relied principally on questionnaire answers whereby it was unverified information;

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

7.4 failed to request a face-to-face consultation with the patient in order to examine the clinical need for the medicine;

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

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

7.7 failed to put adequate safety-netting in place.

8. On 25 June 2020, prescribed 84 tablets of amitriptyline 50mg to Patient 2 in circumstances where you:

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

8.2 relied principally on questionnaire answers whereby it was unverified information;

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

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

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

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

8.7 failed to put adequate safety-netting in place.

9. On some or all of the occasions set out in Schedule A you prescribed the medicines to the patients outlined in that schedule in circumstances where you:

9.1 knew or should have known that the patient had already made repeated orders for the same medicine or other medicines from UK Meds;

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

9.3 relied principally on questionnaire answers whereby it was unverified information;

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

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

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

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

9.8 failed to put adequate safety-netting in place.

10. In relation to 1 above, you prescribed all or some of the medicines in Schedule B to patients in approximately the quantities outlined in that schedule on the basis of an online questionnaire when they were unsuitable to be prescribed on that basis.

11. Your approach to prescribing in all or some of the Allegations 1 to 9 was transactional in that you were processing patient requests by reference to a patient completed questionnaire rather than prescribing in accordance with UK prescribing guidance.

12. Between approximately July 2020 to September 2021 while working as Clinical Lead failed to ensure that other prescribers working for UK Meds, in respect of approximately 14,259 prescriptions for high risk medicines:

12.1 obtained adequate information in relation to the patients' health in advance of prescribing;

12.2 did not rely principally on questionnaire answers whereby it was unverified information and/or;

12.3 accessed and/or attempted to access patients' GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addition history.

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

BEFORE THE FITNESS TO PRACTISE COMMITTEE OF THE GENERAL PHARMACEUTICAL COUNCIL

IN THE MATTER OF A PRINCIPAL HEARING

IN THE MATTER OF MR MOHAMMED HABIB

PARTICULARS OF ALLEGATION

SCHEDULE A

Date (s)	Medicine/quantity	Patient Customer ID/Patient No.
11 March 2020	Amitriptyline 25mg x 56	28505
4 June 2020	Amitriptyline 25mg x 56	28505
15 September 2020	Amitriptyline 25mg x 56	28505
5 November 2020	Amitriptyline 25mg x 56	28505
11 March 2020	Amitriptyline 25mg x 28	73391
19 January 2021	Amitriptyline 25mg x 56	73391

23 February 2021	Amitriptyline 25mg x 28	73391
29 April 2020	Amitriptyline 50mg x 84	434570
23 July 2020	Amitriptyline 50mg x 84	434570
11 October 2020	Amitriptyline 50mg x 84	434570
2 August 2020	Propranolol 40mg x 84	66417
11 November 2020	Propranolol 40mg x 84	66417
10 January 2021	Propranolol 40mg x 84	66417
3 October 2021	Propranolol 40mg x 84	66417
14 May 2020	Propranolol 40mg x 84	169369
12 July 2020	Propranolol 40mg x 84	169369
14 October 2020	Propranolol 40mg x 84	169369

6 October 2021	Propranolol 40mg x 84	169369
20 February 2020	Propranolol 40mg x 84	176476
7 January 2020	Propranolol 40mg x 56	209292

BEFORE THE FITNESS TO PRACTISE COMMITTEE OF THE GENERAL PHARMACEUTICAL COUNCIL

IN THE MATTER OF A PRINCIPAL HEARING

IN THE MATTER OF MR MOHAMMED HABIB

PARTICULARS OF

ALLEGATION SCHEDULE

B

Medicine	No. of prescriptions
Z drugs	18
Opioids	61
Modafinil	5
Amitriptyline	610
Propranolol	2086
Carbamazepine	19
Orlistat/Xenical	1007
Promethazine	933

Metformin	1162
Ventolin	7595

Documentation

1- GPhC hearing bundle 1985 pages

2- GPhC skeleton argument 21 pages

3- Registrant's First Statement signed 5 January 2025 41 pages

4- Registrant's Bundle at fact stage 80 pages

5- Registrant's Bundle at impairment stage 98 pages. This bundle contained a reflective statement from the Registrant dated 26 January 2025.

6- Registrant's written submissions on impairment 18 pages

Witnesses

Fact stage

No Witnesses gave evidence at the facts stage although the Committee read the evidence of

1. Dr GC who produced expert reports dates 20 June 2022 and 15 May 2023
2. Ms 1 statement dated 3 August 2023
3. Ms 2 statements dated 3 July 2023 and 11 November 2024
4. Mr 1 statement dated 1 August 2023
5. Ms 3 statement dated 29 June 2023
6. Ms 4 statement dated 22 April 2024.

Impairment stage

The Registrant gave evidence at the impairment stage

Dr DR gave evidence at impairment stage

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* revised March 2024 (the guidance).

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.

Application to amend the Particulars of Allegation.

6. The Committee agreed to amend the body of particular 4.3 of the Allegation to change the reference to 4.3 to say 4.2. This amendment was made in order to correct a typographical error. Both parties agreed to the amendment and the Committee was satisfied that the amendment was necessary to give the intended sense to particular 4.3 and could be made without any injustice.

Registrant's response to Particulars of Allegation

7. The Registrant admitted all particulars of the Allegation.

8. In the light of the above, and by the application of Rule 31(6) of the Rules, all the factual particulars were announced to be admitted and found proved.

9. The Committee went on to consider whether the Registrant's fitness to practise is currently impaired which is a matter for the Committee's judgement.

Procedure adopted at the fact stage.

10. Before setting out the background to this case, the Committee wishes to record the procedure it adopted when the Registrant admitted all the particulars in the Allegation.

11. Mr. Hoskins, on behalf of the Council, opened the case in detail to the Committee. He drew upon his written skeleton argument and statement of case and also took the Committee to relevant documents, including guidance documents issued for pharmacist prescribers.

12. At the Committee's request, Mr. Hoskins took the Committee to the specific duties, set out in the guidance, that the Council said gave rise to a duty which the Registrant had implicitly acknowledged each time he admitted that he "failed" to do something set out in the particulars of the Allegation.

13. When Mr Hoskins had completed his opening remarks to the Committee, Ms Maudsley acknowledged, on the Registrant's behalf, that he agreed he was subject to each of the duties outlined by Mr Hoskins, that he did not dispute any of the evidence of the witnesses whose statements are set out above and in particular accepted the views set out in Dr GC's reports referred to above.

14. In those circumstances the Committee was satisfied that the Registrant had admitted all particulars of the Allegation on the factual basis advanced by the Council. Accordingly, the Committee is satisfied that the background set out below amounts to agreed facts and the Committee refers to the source of the facts only where it is relevant to do so.

Background

15. The Registrant qualified as a pharmacist in 2007. He worked as a locum pharmacist from 2009 to 2012 and was deputy pharmacy manager at Tesco Pharmacy from 2012 to 2015. In 2017 he completed a qualification to work as a pharmacist prescriber (a PIP) and worked in this role at a GPs practice from April 2017 to end of November 2018. During that time, he expanded his field of prescribing to cover acute medicine. In 2015, the Registrant also started to work for the GP out of hours service for Hampshire. Initially, he worked as a pharmacist prescriber and latterly, in his role as a pharmacist prescriber. The service dealt with out of hours enquiries made largely by telephone.

16. In November 2019, the Registrant joined an online pharmacy service known as UK Meds, initially as a pharmacist prescriber on an hourly rate of £35 per hour. In July 2020, he took on the role of joint Clinical Lead until September 2021. He resigned from UK Meds on 10 July 2022. Throughout the time he was employed by UK Meds, the Registrant worked remotely from home.

17. The Allegation which the Registrant admitted, arose from his time employed by UK Meds. For that reason, the Committee needs to set out something of the organisation and regulatory history of UK Meds.

18. UK Meds first registered on 15 August 2017 and voluntarily removed itself from the GPhC's register on 11 March 2019. Shortly before voluntarily de-registering, it obtained a second registration linked to a physical address at a pharmacy in Nottingham on 1 March 2019. UK Meds was voluntarily removed from the register on 7 September 2021.

19. UK Meds' primarily operated as an online pharmacy 7 days a week. Customers would access its website and, initially at least, chose the sort of medication they wanted and fill in an online questionnaire. This questionnaire would be considered by a prescriber working remotely. Initially prescribers were a team of GMC registered doctors but, from around September 2019 (shortly before the Registrant joined UK Meds), prescribing responsibility had shifted to a team of PIPs. The PIPs would be supervised and, at least by the time the Registrant occupied the position, monitored by the Clinical Lead who would themselves also issue prescriptions in addition to their supervisory function. It is this role that the Registrant occupied from July 2020 until September 2021.

20. Following a prescription being issued by a PIP, it would be dispensed by the in-house pharmacy team within UK Meds' physical premises in Nottingham or an associated pharmacy and delivered by post or courier.

21. During its period of registration, UK Meds was inspected twice by the Council, served with three improvement notices and three Notices of Conditions, restricting its prescribing.

22. Although some of the inspections were carried out before the Registrant began work with UK Meds, it is important to note the concerns with the UK Meds that were raised at an early stage.

23. In March 2019 UK Meds was made subject to a Statutory Improvement Notice following a number of concerns from patients, family members and General Practitioners that vulnerable patients have been supplied medicines that are clinically inappropriate. The required improvements included that identity checks were strengthened, multiple orders were identified as well as all relevant information was

obtained from patients and that relevant information about the prescription is shared with other healthcare professionals.

24. An inspection on 3 September 2019 identified systemic weaknesses with the safe delivery of pharmacy services, including absences of risk assessments particularly in relation to higher-risk medicines liable to addiction and abuse, overuse or misuse, and medicines requiring ongoing monitoring or management. There was a reliance mainly on questionnaire answers provided by the patient, but the system would prompt a patient when their answer would prevent supply and allow changes to be made.

25. On 27 September 2019, a Statutory Improvement Notice was served on the Pharmacy requiring it to complete risk assessments of all services, make changes to the website (including that it must not indicate which answers raise questions about clinical appropriateness and the PIPs share relevant information about prescriptions issued with GPs and contacts them in advance of prescribing.

26. On 1 November 2019, despite some improvement in the online form so that patients were not prompted to change some answers, conditions were imposed prohibiting the sale or supply of schedule 1 to 5 controlled drugs and modafinil.

27. A further inspection on 7 October 2020 revealed that UK Meds was still unable to show that all risks linked to the supply of medicines online had been identified and managed appropriately (including those with higher toxicity in overdose and amitriptyline).

28. In particular, the inspectors noted that there was significant reliance on patients' online questionnaire answers, which were not routinely asked to be supplemented by evidence indeed, opportunities to confirm the reliability of patient's self-reported answers in the questionnaire were not taken. There remained no face-to-face contact between PIPs and patients. GPs were not routinely contacted even when consent was given, nor were the risks considered where consent was withheld.

29. On 9 March 2021, a further Improvement Notice was issued, this time with the condition not to supply amitriptyline, on the basis that The Pharmacy continued to

supply it based on the patient questionnaire with no input from a patient's GP and no access to summary care records, resulting in a number of patient safety incidents.

30. On 24 March 2021, the Council wrote to UK Meds setting out UK Meds' failure to comply with the October 2020 Improvement Notice. The Council pointed out the absence of evidence that UK Meds were contacting GPs.

31. On 30 July 2021 a final Improvement Notice was issued to UK Meds to prevent it advertising links to a linked EU corporate entity registered in the UAE so outside UK regulation via its UK Meds website, social media and direct text messaging.

32. That notice set out that the UK Meds remained an online pharmacy with no face-to-face contact, no evidence of information sharing with GPs and based on patients' responses to an online questionnaire and notes: "*The pharmacy has consistently failed to meet the standards set under article 7(1) of the Pharmacy Order 2010, established to ensure safe and effective pharmacy care. It has consistently failed to show that it understands or appreciates the risks of supplying medicines at a distance and has failed to mitigate or remedy these risks".*

33. As indicated above, UK Meds was voluntarily removed from the register on 7 September 2021.

The regulatory framework for remote prescribing

34. Before turning to the conduct of the Registrant, it is necessary to record the regulatory framework within which the Registrant worked. There is no dispute that this framework gave rise to the various duties he admits he failed to fulfil in his admissions to the Allegation.

35. The first source of guidelines from which the duties arise is In practice: Guidance for pharmacist prescribers 2019. The Committee have had particular regard to the following passages.

    a. *Pharmacist prescribers are responsible for creating a culture of personcentred professionalism wherever they work, and for ensuring prescribing itself and prescribing services are delivered safely and effectively.*

b. *Any prescribing decisions must be made in partnership with the person being assessed, to make sure the care meets their needs and that the pharmacist prescriber has consent to prescribe, when this is appropriate.*

c. *Pharmacist prescribers must communicate effectively with the person to:*

   • *understand their needs*

   • *make sure there is a genuine clinical need for treatment*

   assess whether the person has the capacity to make a decision about their care or consent.

   • *come to a shared decision about the care they provide. They must do this by getting all the relevant information from the person, and giving the person – and carer whenever appropriate – all the relevant information in a way they can understand, so they can make an informed decision and choice.*

   • *make sure the person is aware of any risks involved in their treatment and the risks of any reasonable alternative or different treatment option*

d. *To prescribe safely, it is important to be able to have access to a person's medical records. However, access may not be possible or may be limited, and there are potential risks in prescribing without these records. Pharmacist prescribers should assess whether they have sufficient information and knowledge of the person's health and medical history to make an assessment of the condition. This includes using medical records such as the summary care record (SCR) (in England),*

e. *Pharmacist prescribers must ask the person for consent to access their medical records, or to get other reliable information about the person's health and medicines from their regular prescriber if they have one. To ensure person-centred care, they must give clear information, so that the person receiving care can make an informed decision, and must discuss other available options when it is not appropriate to prescribe.*

f. *Prescribing information should be shared with the person's prescriber, or others involved in their care, so the person receives safe and effective care. Pharmacist prescribers should use their professional judgement when deciding what information to share3 . This is especially important when prescribing medicines that are liable to abuse, overuse or misuse, when there is a risk of addiction or when ongoing monitoring is important.*

36. Within the same guidance, the Committee noted the guidance in respect of *Online prescribing and safeguards for the online prescribing of certain medicines.*

a. *More and more often, people are using pharmacist prescribers at a distance, rather than in the traditional face-to-face way. This will be either by phone or video link, or more usually online through prescribing services. In these cases, as well as keeping to section 1 of this guidance on prescribing safely, pharmacist prescribers must make sure patient safety is not compromised. This is especially important when the person is vulnerable or at risk of addiction to certain medicines.* ***Pharmacist prescribers must make an adequate and safe clinical assessment, communicate effectively and get the person's consent to access their medical record. It is especially important when prescribing at a distance that pharmacist prescribers assess the capacity of the person seeking care****.*

b. *Prescribing medicines at a distance, either as part of an online prescribing service or independently over the internet, brings different risks from those when there is a face-to-face consultation.* ***Certain medicines are not suitable to be prescribed online (for example nonsurgical cosmetic products), and for some medicines there should be extra safeguards in place.***

c. *In light of the very real patient safety risks,* ***pharmacist prescribers must not make prescribing decisions for high-risk medicines based mainly on online questionnaires with no access to the person's medical history or consent to contact the person's regular prescriber. (High-risk medicines are, for example, those liable to abuse, overuse or misuse, or when there is a risk of addiction and ongoing monitoring is important.)*** *Appropriate risk management and*

safeguards must be in place, or the registration of the pharmacist prescriber could be at risk.

d. *Pharmacist prescribers are accountable for their prescribing decisions, including when prescribing at a distance. They should prescribe only when they have adequate knowledge of the person's health and their full medical and prescribing history: for example, by using the person's medical records and other sources of information to establish any allergies or interactions. They must be satisfied that the medicines serve the person's needs. Any decisions about treatment are for both the pharmacist prescriber and the person to consider together during the consultation.*

e. *If the pharmacist prescriber has not carried out a face-to-face consultation with the person, they should explain to the person how the remote consultation will be carried out.*

37. The Committee also had regard to the guidance in respect of medicines falling into the following categories:

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

38. The Committee observed that the guidance provides that:

If a pharmacist prescriber decides to prescribe at a distance or work with an online prescribing service, the above categories of medicines should not be prescribed unless the prescriber:

- has robust processes in place to check the identity of the person
- has asked the person for the contact details of their regular prescriber, such as their GP, and for their consent to contact them about the prescription
- will proactively share all relevant information about the prescription with other health professionals involved in the care of the person (for example their GP)
- has systems in place for circumstances when the person does not have a regular prescriber such as a GP, or there is no consent to share information, and the pharmacist prescriber has decided, in exceptional circumstances, still to issue a prescription. They should make a clear record setting out their justification for prescribing (for example: how they have kept any risks as low as possible; the immediate need; how they have arrived at their decision to prescribe;

39. The second source of guidance is *A Competency Framework for all Prescribers* issued by the Royal Pharmaceutical Society in 2016.

40. That document states that it is based upon and updates the framework set out National Prescribing Centre/National Institute for Health and Clinical Excellence (NICE) in 2012. It provides the following:

    a. It is a generic framework for any prescriber (independent or supplementary) regardless of their professional background. It therefore does not contain statements that relate only to specialist areas of prescribing.

    b. It sets out 6 competencies for a prescriber:

        1. Assess the patient

        2. Consider the options

        3. Reach a shared decision

        4. Prescribe

5. Provide information

6. Monitor and review

c. The Committee has had particular regard to

1.2 Undertakes an appropriate clinical assessment.

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

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

4.2 Understands the potential for adverse effects and takes steps to avoid/minimise, recognise and manage them.

4.7 Considers the potential for misuse of medicines.

41. The Committee also had regard to the General Medical Council Good practice in prescribing and managing medicines and devices (2013) (the GMC Guidance)

42. It is agreed by the parties that this guidance applies to all prescribers. The Committee will refer to particular passages below, if necessary, but at this stage observes that the guidance emphasises the importance of communication with a patient and emphasises the need to contact a patient general practitioner "if you need more information or confirmation of the information you have before prescribing".

43. The Committees attention was drawn to other available guidance, to which the Committee will refer below if necessary.

44. The Committee also read the two reports of Dr GC which are referred to above. Dr GC's evidence was accepted in full by the Registrant and can therefore be summarised relatively briefly as follows. The prescribing practice carried out by the Registrant while working with UK Meds was fundamentally unsafe because his prescribing was:

a. *based on an uncorroborated questionnaires whether for new or repeat medication*

b. without access to medical records or without communication with their GP

c. without face-to-face contact nor a two-way dialogue, for example via video link

d. and without the provision of adequate monitoring and following up (safety-netting) which the PIP can be confident has been understood.

Dr GC's evidence

45. Dr GC explained her reasons in the following terms:

a. In my opinion, and experience, the two way dialogue of the consultation is the key to safe prescribing. A clinician must make an assessment of the knowledge-base, age, language, physical or sensory impairments of a patient and then base their discussion at a level appropriate to each individual patient.

b. Turning to the importance of clinical information she said: *In my opinion, without this clinical information, it is unsafe for a clinician to prescribe any medication. I am not, in this report, referring to immediate and necessary emergency treatment of a patient but routine consultations and prescribing. In such a medical emergency, in my opinion, medication prescribed should be the most appropriate drug, at the lowest dose for the shortest period of time and only when the prescriber is satisfied, by a face to face assessment, that they can evidence that the prescription is necessary, is required urgently and immediately and that the dose is correct. In the case of emergency prescribing from an online questionnaire, as in the case for UK Meds Ltd, the face to face assessment is missing, the patient's current health assessment is missing, corroboration of an existing prescription or allergy is missing, past medical history is not evidence other than that self-reported and informed consent cannot be given."*

c. In the case of online remote prescribing, in my opinion, this 2 way communication is absent as the Clinician is wholly reliant on the self-reported clinical information provided, in the online questionnaire, by the patient. Therefore, in my opinion, there is no corroboration of symptoms, no physical assessment, no confirmation of current or past health or medication prescribed. In my opinion, online prescribing from self-reported questionnaires is insufficient

to enable safe and appropriate, evidence based prescribing. In my opinion, it is only by speaking to the patient that a prescriber can determine underlying emotions , anxieties and current mind set of a patient, thereby adapting treatment options to the patients underlying condition and treatment goals.

46. Dr GC also drew attention to the particular danger of prescribing by online a list of drugs now set out in Schedules A and B of the Allegation, indicating in each case the dangers of abuse, dependence, overdose, cardiac arrythmia, foetal harm and mental health issues, including depression.

The Particulars of Allegation admitted by the Registrant

47. The Committee then turned to the particulars of the Allegation which were admitted by the Registrant. For the sake of completeness, the Committee notes those Particulars that the Registrant denied in his statement of 5 January 2025.

48. **Particulars 1 and 2** simply reflect the Registrant's role in UK Meds and the number of times he prescribed medication, including 4,859 when he prescribed high-risk medication.

49. **Particular 3** sets out the Registrant's failure to prescribe in accordance with the guidance set out above by reference to the 7 failures set out in the Particular, including a failure to access/attempt to access patient records, failure to consider medication, failure to request face to face consultation failure to identify the risk of misuse and failure to refer patients back to their GP.

50. The Committee observes that the Registrant denied this particular of the Allegation in his statement of 5 January 2025 apart from "relying principally on the information received in an online questionnaire" and failing to request face to face consultation.

51. **Particulars 4 and 5** relate to the prescribing model at UK Meds, as a whole. Particular 4 relates to the period up to 6 October 2020, when a patient was alerted to an answer that would prevent prescription and could change the answer. Particular 5 relates to the period from 6 October when that was no longer possible, but it was still the case that the prescribing model was such that no face-to-face consultation

took place and patients provided information primarily through an online questionnaire.

52. The Committee observes that the Registrant denied much of this particular in his statement of 5 January 2025, although it was not clear if he acknowledged in his statement that the model was in any event incapable of supporting safe prescribing.

53. **Particular 6** alleges that the Registrant prescribed "in circumstances where the time taken would not have been sufficient to evaluate the suitability of the medicines to the patient". The particular sets out 5 ways in which the lack of time impacted adversely on prescribing.

54. The agreed analysis of the Registrants prescribing showed 28,816 prescriptions dealt with in under a minute, 12,960 in less than 3 minutes and only 16,570 dealt with in more than 5 minutes.

55. The Committee observes that in his statement of 5 January 2025, the Registrant denied this particular and maintained that he did have sufficient time to prescribe safely.

56. **Particular 7** arises from the Registrant prescribing 28 tablets of propranolol on 25 June 2020 to a patient identified as Patient 13. He has admitted the same 7 failings that he admitted in respect of his prescribing in particular 3. In this case the patient died on 19 June 2021 from an overdose of propranolol. Her death was found to be suicide.

57. It is agreed that Patient 13 had been an in-patient in a psychiatric hospital since June 2020 and had been detained under Section 3 of the Mental Health Act since September 2020. The patient obtained the fatal dose of medication whilst on home leave from hospital. It is not suggested that she obtained the fatal dose from the Registrant but it became apparent at the inquest that she had obtained this medication (which he had used in past overdoses) from 7 different online pharmacies. The Registrant was identified as one of those who had prescribed to patient 13 and gave evidence at the inquest.

58. The Council's case is that the danger of the Registrant's inappropriate prescribing is demonstrated by this case.

59. **Particular 8** arises from the Registrant prescribing 84 tablets of amitriptyline on 9 August 2020 to a patient identified as patient 2. This was the fourth supply to Patient 2 from UK Meds. The Registrant has admitted the same 7 failings that he admitted in respect of his prescribing in particular 3. In this case the patient died on 9 August 2020, from an overdose of Codeine.

60. Despite patient 2 dying relatively soon after the Registrant prescribed medication to her, it is not suggested that his prescribing lead directly to her death. The inquest noted that she died from an overdose of a different drug. Nevertheless, the inquest identified the ease with which this patient had acquired drugs from a number of pharmacies without any of them contacting her GP.

61. The Council's case is that the danger of the Registrant's inappropriate prescribing is demonstrated by this case.

62. The Committee observes that in his statement of 5 January 2025, the Registrant maintained that he had acted reasonably in the circumstances of the Covid-19 lockdowns.

63. **Particular 9** arises from 20 examples of the Registrant prescribing either Amitriptyline or Propranolol to patients who had previously been supplied with these medications by UK Meds, including by the Registrant, on multiple occasions.

64. The Committee observed that in his statement on 5 January 2025 the Registrant accepted that he had prescribed without knowledge of previous prescriptions but maintained that he had adequate information to prescribe safely from the written questionnaires.

65. **Particular 10** arises from the Registrant prescribing 10 medications identified by Dr GC as unsuitable for prescription on the basis of an online questionnaire. Schedule B records that this occurred on over 13,000 occasions.

66. The Committee observed that the Registrant denied this allegation in his statement on 5 January 2025 and argued that Dr GC was wrong to characterise these medications in that way

67. **Particular 11** alleges that the Registrant's approach to prescribing in all or some of the Allegations 1 to 9 was transactional in that he was processing patient requests by reference to a patient completed questionnaire rather than prescribing in accordance with UK prescribing guidance. The Council submitted that he was prioritising the commercial transactions undertaken by UK Meds over the safeguarding of the patients' and reliance on his clinical judgment.

68. The Council's case is that this is demonstrated by:

a. the risk profile of the medications (including controlled drugs for one month in November 2019);

b. the speed of prescribing;

c. the uncritical and total reliance on questionnaire based consultation mostly uncorroborated;

d. the length of time over which such matters occurred in a private setting; and

e. the experience of the Registrant.

69. The Committee accept that, by his admission to particular 10, the Registrant accepted that this is correct.

70. The Committee observed that in his statement of 5 January 2025, the Registrant denied this particular and maintained that he had prescribed in accordance with guidance.

71. **Particular 12** arises from the Registrant's employment as "Clinical Lead" and his failure to ensue proper prescribing by other prescribers in respect of approximately 14,259 prescriptions. The particular contains three examples of his failures.

72. The Committee observed that in his statement of 5 January 2025 the Registrant denied this particular on the basis that he was not responsible for the prescribing of others. The Committee observes that his admission is consistent with the evidence of

the inspections and the Registrants statement to Ms 2 *that "The CL will look at most of the prescriptions every day."*

MISCONDUCT AND IMPAIRMENT

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

Evidence

74. The Committee heard evidence from the Registrant. He adopted his written reflective statement dated 26 January 2025. He took full responsibility for all his actions while working for UK Meds. He described himself as profoundly disappointed for not appreciating the shortcomings that he displayed at the time. He acknowledged that relying predominantly on a questionnaire-based model without access to comprehensive patient medical records fell short of the standards outlined in the GMC, RPS, and GPhC guidance.

75. He said that, while his intentions were sincerely focused on supporting patients, particularly during the unprecedented challenges of a global pandemic, he now recognised that this approach compromised patient safety and did not meet the professional standards expected of him as an Independent Prescriber. He accepted full responsibility for his actions and their potential consequences.

76. The Registrant described himself as having been naive and said that he regretted any involvement with UK Meds. He said that he realised that UK Meds had deregistered from the Council only when the Council served evidence on him in June 2022.

77. He had accepted, he said, the word of the Superintendent Pharmacist who told him that the Council had never raised any concerns or grievances regarding the UK Meds questionnaire based model. He said that he now understood that his reliance on these assurances and what he described as the normalisation of the model in the sector, led him to overlook the necessary "professional scepticism and diligence".

78. He said that, after “extensive reflection”, he realised that the UK Meds questionnaire based prescribing model was “fundamentally incapable of supporting safe prescribing decisions” he acknowledged that this was aggravated by the lack of access to central medical records and physical examinations. He acknowledged that he had personally failed to facilitate real time interactions with patients, either by video or telephone and observed that there had been little time to follow up or assess a patient’s need for treatment.

79. The Registrant acknowledged that he had breached the following standards of conduct:

a. Standard 1(provide person-centred care)

b. Standard 2 (work in partnership with others)

c. Standard 3 (communicate effectively)

d. Standard 5 (use professional judgement)

e. Standard 6 (behave in a professional manner)

f. Standard 8 (speak up when they have concerns or when things go wrong)

g. Standard 9 (demonstrate leadership).

80. Looking at his practice as a whole, the Registrant acknowledged the importance not only of medical records but of face-to-face examinations and contact with a patient's GP.

81. The Registrant reflected upon the case of Patient 13 and deeply regretted her death. He said that seeing the patient’s family at the inquest had brought into sharp focus the gravity of the prescribing decisions made and the devastating consequences they can have on patients and their loved ones. He offered his apology to the patient’s family for failing to safeguard her.

82. He outlined the remediation he had undertaken in clinical governance, patient safety, and shared decision-making with a particular emphasis on prescribing practices. He described how this had strengthened his understanding of the importance of robust

safeguards thorough patient assessments and two-way communication in ensuring safe and effective care.

83. For the future, he was clear that he would never work again in an online pharmacy and would only work in a reputable NHS organisation.

84. In answer to questions, the Registrant told the Committee that he had submitted his statement on 5 January 2025 without reflecting on the full 2000 page bundle. He said that it had been a difficult journey but he had realised that what he had done amounted to misconduct about a year and a half ago and the January statement was the result of responding quickly to the Allegations without reflecting.

85. He emphasised that he understood that online prescribing, of the sort conducted at UK Meds, was unsafe because there was no dialogue, no access to medical records, no ability to book an appointment, even video conferencing during the pandemic.

86. He acknowledged that he had more oversight of the position when he was Clinical Lead but still did not challenge sufficiently what was happening and allowed himself to be reassured by the Superintendent Pharmacist.

87. In cross examination, Mr Hoskins reminded the Registrant that his insight into the inadequacy's of the online questionnaire as a means of safe prescribing was not merely new but inconsistent. He reminded the Registrant that in his reflection on the death of patient 13, written on 31 august 2022, he had expressed his shock and sadness that the patient had died from an overdose and observed that in future, *"I would not just rely on an Online questionnaire, I would call the patient and take a more in-depth assessment, I would discuss the case with colleagues and specialist. If I felt there was not adequate information or inaccuracies I would refer the patient back to the GP with safety netting, advice and referral to appropriate resources. I would only work for reputable CQC registered entities that have scored good and above within the NHS as part of a Multidisciplinary team with appropriate support."* Nevertheless, he had gone on to state in his statement of 5 January 2025 that he considered the information contained in the online questionnaire to be sufficient for safe prescribing, before resiling from that and concluding once again that it was not.

88. The Registrant replied that the journey of insight had not been an easy one but he now understood the position.

89. The Registrant told the Committee that, at the time he was working for UK Meds, he was aware of the guidance issued by the Royal Pharmaceutical Society but had not read the guidance issued by either the Council or the GMC.

90. Dr DR (who was allowed to give evidence before the Registrant to ensure that he was available to give evidence) told the Committee that he had known the Registrant since he employed him at the out of hours GP service in 2015. He had subsequently helped him with his qualification as a prescriber and allowed the Registrant to shadow him in his surgery for 40 hours in December 2022.

91. Dr DR described how the Registrant had discussed prescribing with him and he was confident that he was now a safe and competent prescriber based on his observation of the Registrant during his time at the out of hours service, until 2019, and his discussions with him during and since December 2022.

92. Dr DR told the Committee that the Registrant had not raised any concerns with him while he was working for UK Meds but had discussed all the Allegations with him since. He told the Committee that initially the Registrant had been angry and felt that he had been unfairly treated but he had come to realise that what he had done was wrong. He said this change had taken place during and towards the autumn of last year.

93. The Committee also saw a log of CPD undertaken by the Registrant provided by Mims learning, showing the topics covered between 5 and 20 February 2023 and a number of certificates of completion. The Committee also read a bundle of reflections between January and August 2024 setting out what the Registrant has learned from his continuing study about how to practise safely.

94. The Committee has also seen a number of favourable testimonials, the most important of which, at this stage, are from the Oak Lodge Medical Centre where the Registrant has worked since January 2023.

95. The practice business and strategic management lead describes him as *"a valuable member of Oak Lodge Medical Centre, consistently demonstrating professionalism, expertise, and a commitment to patient care. His involvement in audits, medication management, and de-prescribing has helped improve the quality of care and streamline processes within the practice. Mohammed is also dedicated to ongoing professional development, contributing to staff training and supporting the team in delivering better patient outcomes… Mohammed's consistent performance and dedication continue to make him a valuable member of the team."*

96. The Clinical Lead pharmacist at the practise also wrote on 24 January 2025 explaining that they had *"worked with the Registrant for two years regularly reviewing his clinical work, attending meetings with him and observing his day-to-day practice."* They have found *"Mohammed to be a clinically competent, diligent, and highly professional pharmacist who consistently upholds the highest standards of pharmacy practice, in line with the nine standards for pharmacy professionals and the expectations outlined by national and local guidelines."*

97. They paid tribute to his communication skills and commitment to professional development, his contribution to training peer discussions, his collaborative working and the way he escalates complex cases to the GPs.

Submissions

On behalf of the Council

98. In written and oral submissions, Mr Hoskins addressed the Committee on the law and guidance relevant to the questions of misconduct and impairment. There was no dispute about the law and guidance that is relevant to the Committee's decision and the Committee has set it out in its approach below.

99. Both counsel acknowledged that this stage is itself a two stage process, in which the Committee must decide first whether what has been proved amounts to serious misconduct and if so, whether the Registrant's fitness to practise is currently impaired.

100. Mr Hoskins submitted that the matters admitted and found proved all amount to serious misconduct. He submitted that the Registrant had breached the following provisions of the Council's Standards for Pharmacy Professionals (May 2017). (the Council's Standards)

Standard 1, providing person-centred care;

Standard 2, work in partnership with others;

Standard 3, Pharmacy professionals must communicate effectively

Standard 5, use professional judgment;

101. Mr Hoskins submitted that the matters proved each amounted to serious misconduct because they not only amounted to a breach of the Standards but put patients at risk of serious harm.

102. He further submitted that the Registrant's fitness to practice is currently impaired both because there remained a risk that the Registrant would repeat misconduct and because a finding of impairment was necessary to promote and maintain public confidence in the profession and promote and maintain standards of conduct.

Submission on behalf of the Registrant

103. Ms Maudsley also assisted the Committee with the relevant law and guidance. She acknowledged that decisions about misconduct and impairment were a matter for the Committee, regardless of any admissions by the parties.

104. With regard to the issue of misconduct, Ms Maudsley accepted that the Registrant had breached the following of the Council's Standards:

Standard 1 (provide person-centred care)

Standard 2 (work in partnership with others)

Standard 3 (communicate effectively)

Standard 5 (use professional judgement)

Standard 6 (behave in a professional manner)

Standard 8 (speak up when they have concerns or when things go wrong)

Standard 9 (demonstrate leadership).

105. She accepted that the matters admitted and found proved amounted to misconduct.

106. Turning to impairment, Ms Maudsley drew the Committees attention to the evidence of the Registrant's insight and remediation and submitted that there was no longer a risk that the Registrant would repeat misconduct in the future. She reminded the Committee of the work the Registrant had done working for two years in a GP practice and the favourable testimonials.

107. She also submitted that the Committee should not equate the Registrants statement of 5 January 2025 and his late admissions as showing a lack of insight and drew the Committee's attention to authorities which provide that even denials are not a bar to a Registrant demonstrating insight.

108. Ms Maudsley submitted that, in all the circumstances, the Registrant's fitness to practise was not currently impaired.

The Committee's approach to misconduct

109. The Committee reminded itself that this stage of the proceedings is itself a two stage process. The Committee must first decide whether the matters admitted and found proved amount to serious misconduct and if it concludes that they do, it must go on to consider whether the Registrant's fitness to practise is currently impaired.

110. Turning to the question of misconduct the Committee reminded itself of the case of **Roylance v GMC (No.2)** [2000] 1 AC 311, para 38 in which the court stated that 'misconduct' was:

"a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed…in the particular circumstances…And such falling short must be serious."

111. In deciding whether misconduct is serious, the Committee followed the approach set out in **Solicitors Regulation Authority v. Day and others** [2018] EWHC 2726 (Admin)

which gave the following guidance to Committees: "*We do not, we emphasise, say that there is a set standard of seriousness or culpability for the purposes of assessing breaches of the core principles in tribunal proceedings. It is a question of fact and degree in each case. Whether the default in question is sufficiently serious and culpable thus will depend on the particular core principle in issue and on the evaluation of the circumstances of the particular case as applied to that principle."*

112. The Committee also had regard to the provisions of the Council's Standards as set out in the Committee's decision.

The Committee's approach to impairment

113. Turning to the question of impairment, the Committee reminded itself that impairment is a matter for its own professional judgement. It is not bound to accept the submissions of the parties, even if they are agreed, and must decide the issue of impairment for itself.

114. The Committee bore in mind that a finding of impairment is separate from the finding of misconduct and that a finding of misconduct does not automatically mean that the practitioner's fitness to practise is impaired.

115. The Committee reminded itself that it must decide current impairment and that is a significant consideration when nearly 3 years have elapsed since the Registrant's misconduct, there has been no repetition and there is evidence that he has developed insight and taken steps to remediate.

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

117. The Committee had regard to Paragraph 2.11 of the Guidance which provides that:

> *"A pharmacy professional is 'fit to practise' when they have the skills, knowledge, character, behaviour and health needed to work as a pharmacist…safely and effectively. In practical terms, this means maintaining appropriate standards of competence, demonstrating good character, and*

also adhering to the principles of good practice set out in your various standards, guidance and advice."

118. The Committee also had regard to Rule 5(2) of the rules which provides:

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

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

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

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

(d) shows that the integrity of the Registrant can no longer be relied on."

119. The Committee had regard to paragraph 2.15 of the Guidance which provides that the Committee should consider whether:

• the conduct which led to the complaint is able to be addressed

• the conduct which led to the complaint has been addressed

• the conduct which led to the complaint is likely to be repeated

• a finding of impairment is needed to declare and uphold proper standards of behaviour and/or maintain public confidence in the profession.

120. The Committee also had regard to the following passages in the judgment of Cox J in the case of **High Court in *CHRE v NMC and P Grant [2011] EWHC 927 (Admin)***: *"Do our findings of fact in respect of the (Registrant's) misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*

a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b) *has in the past brought and/or is liable in the future to bring the …..profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future."*

e) It examined the risk that the misconduct found would be repeated and reminded itself of the observations of Silber J in **Cohen v GMC [2008] EWHC 581 (Admin):**

> *"There must always be situations in which a Committee can properly conclude that the act of misconduct was an isolated error on the part of a medical practitioner and that the chance of it being repeated in the future is so remote that his or her fitness to practice has not been impaired. Indeed, the Rules have been drafted on the basis that once the Committee has found misconduct, it has to consider as a separate and discreet exercise whether the practitioner's fitness to practice has been impaired."*

121. The Committee also had regard to the following guidance from the same case:

> "*Any approach to the issue of whether a doctor's fitness to practise should be regarded as 'impaired' must take account of 'the need to protect the individual patient, and the collective need to maintain confidence [in the] profession as well as declaring and upholding proper standards of conduct and behaviour of the public in their doctors and that public interest includes amongst other things the protection of patients, maintenance of public confidence in the (profession)'*

122. The Committee reminded itself that the importance of considering the wider public interest in promoting and maintaining confidence in the profession and maintaining standard of conduct was approved in the Grant case (above) and repeated in a number of subsequent cases.

The Committee's decision on misconduct

123. The Committee found that as well as breaching the guidance given by the Council, the GMC and the Royal Pharmaceutical Society, the Registrant had breached the following provision of the Standards.

Standard 1 (Pharmacy professionals must provide person-centred care)

Standard 2 (Pharmacy professionals must work in partnership with others)

Standard 3 (Pharmacy professionals must communicate effectively)

Standard 4 (Pharmacy professionals must maintain, develop and use their professional knowledge and skills)

Standard 5 (Pharmacy professionals must use their professional judgement)

Standard 6 (Pharmacy professionals must behave in a professional manner)

Standard 8 (Pharmacy professionals must speak upspeak up when they have concerns or when things go wrong)

Standard 9 (Pharmacy professionals must demonstrate leadership).

124. Looking at each of the matters proved against the Registrant, the Committee was satisfied that, working remotely and dealing with a very large volume of material, the Registrant was not providing person centred care but was focused instead upon meeting targets. It is implicit in all the findings that the Registrant did not communicate effectively either with patients or colleagues.

125. The Committee has added a breach of standard 4 to reflect the Registrants admission during the hearing that he had not read the Council's or GMC's guidance which applied to him whilst prescribing remotely.

126. The Committee was also satisfied that the procedures carried out by the Registrant were not conducted in a professional manner, focused upon his professional obligations. The Registrant has admitted that he did not speak up when he knew things were not being conducted properly and he did not demonstrate leadership to his colleagues even when he was in a leadership or management role.

127. The Committee has applied these considerations to each of the matters admitted and found proved from particular 3 to particular 12. It acknowledges that not every breach of the standards will amount to misconduct. but is satisfied in this case that the breaches each amount to serious misconduct because they put patients at significant risk of serious harm.

128. The Committee considered whether it should apply the same considerations to particulars 1 and 2 but felt that the fairest way to approach to those particulars of the Allegation was to regard particulars 1 and 2 as simply setting the background for the numerous failures and breaches set out in the remaining particulars.

The Committee's decision on impairment

129. In order to answer the questions set out in Rule 5(2) and in the Grant case (above), the Committee considered the issue of whether there was a risk or potential risk that the Registrant would repeat his misconduct in some form in the future.

130. The Committee had careful regard to Ms Maudsley's persuasive submissions. The Committee also had regard to the Registrant's evidence, the evidence of Dr DR and the evidence that the Registrant has worked effectively for two years in a GP's practice, where he is held in high regard.

131. The Committee has also reminded itself that a very large part of the Registrant's insight is very recent and there is concerning evidence that his insight has proved fragile in the past. The Committee observed that, while the Registrant has developed an understanding that what he did was wrong, he has not yet demonstrated that he understands why he acted as he did, in way that would give a Committee reassurance for the future.

132. In those circumstances, the Committee is persuaded that the Registrant is sincere in what he has said to the Committee but has concluded that his insight is recent and incomplete and remains fragile until he has demonstrated that he can maintain his insight and continue the personal and professional development he has begun.

133. Accordingly, the Committee accepted that the risk of the Registrant repeating his misconduct is significantly reduced but he still presents a potential risk at this time.

134. The Committee has already found that the Registrant put patients at unwarranted risk of serious harm and has concluded that, while a risk of repetition remains, there is an unacceptable risk that he will do so in the future.

135. The Committee is satisfied that the Registrant's misconduct has brought the profession into disrepute by his role at UK Meds and there remains a risk of him doing so in the future.

136. The Committee then considered whether the Registrant is someone whose integrity can no longer be relied upon. The Committee concluded that while he was working at UK Meds and prescribing in a way that fell significantly short of his professional obligations, the Registrant did behave without the integrity expected of a registered pharmacist. The Committee has also concluded that there remains, an albeit reduced, risk of misconduct in the future. Nevertheless, having regard to the insight that the Registrant has now developed and the evidence that he has worked well for two years the Committee is not satisfied that there is sufficient material from which it could conclude that his integrity cannot currently be relied upon.

137. Taking the misconduct and the Registrants reaction to it in the context of his good record of practice before he worked at UK Meds and the good work he has done since, the Committee concluded that the Registrants misconduct is remediable, and he has demonstrated that he is capable of remediating. Nevertheless, the Committee concluded that the process of gaining insight and remediating is not yet complete.

138. The Committee also reminded itself that when considering the issue of impairment, it must have regard to the wider public interest of maintaining public confidence in the profession and upholding standards of conduct.

139. The Committee reminded itself of the seriousness of the Registrants misconduct and the effect upon public confidence of his role at UK Meds. For these reasons, the Committee was satisfied that a finding of impairment was necessary in the wider public interest to demonstrate that the misconduct in this case is unacceptable to the profession.

140. Accordingly, the Committee finds that the Registrant's fitness to practise is impaired both because of the need to protect the public in the future and also because of the need to promote and maintain public confidence in the profession and proper professional standards of conduct.

Decision on Sanction

141. Having found the Registrant's fitness to practise impaired for the reasons set out above, the Committee went on to consider the question of what, if any, sanction to impose.

The Committee's approach

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

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

144. The Committee took into account the Council's '*Good decision making: Fitness to practise hearings and outcomes guidance', revised in 2024* (the Guidance).

145. The Committee reminded itself that any sanction imposed must be proportionate, that is to say it must balance the need to protect the public against the rights of a Registrant to practise his profession and be no more restrictive than is necessary to protect the public and the wider public interest.

146. The Committee had regard to paragraph 5.7 of the guidance which provides:

5.7 In reaching a decision on what outcome to impose, the Committee should give appropriate weight to the wider public interest. In the context of a fitness to practise hearing, public interest considerations include:

- *protecting the public*
- *maintaining public confidence in the profession*
- *maintaining proper standards of behaviour*

148 The Committee reminded itself of the decision of the High Court in Bolton v Law Society [1994] 2 All ER 486 at paragraph 14 is relevant:

"It often happens that a solicitor appearing before the tribunal can adduce a wealth of glowing tributes…He can often show…the consequences of striking off or suspension would be little short of tragic. Often he will say convincingly that he has learned his lesson and will not offend again…But none of them touches the essential issue, which is the need to maintain among members of the public a well-founded confidence that any solicitor who they instruct will be a person of unquestionable integrity, probity and trustworthiness.

The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is part of the price."

Submissions

147. Mr Hoskins drew the Committees attention to the law and guidance relating to sanction in this case. The Committee is satisfied that there is no dispute between the parties as to the relevant law and guidance that is set out above.

148. Mr Hoskins submitted that the following matters summarised the gravity of the Registrant's misconduct:

a. *By the time of commencing his employment at UK Meds, the Registrant cannot properly be regarded as lacking experience in the field of prescribing nor the practice of pharmacy more generally. He was more than adequately qualified, experienced and competent to recognise and act upon the shortcomings in the system of care at UK Meds.*

b. *The matters admitted and found proved, taken together demonstrate not a few lapses but a significant number of failures in a role of fundamental importance over a period of years.*

c. *The severity of risk to patients in the Registrant's actions in respect of the thousands of prescriptions of high-risk medications (particular of Allegation 2) based on an unsafe methodology employed at UK Meds (particular of Allegation 3-5).*

d. *Although the methodology was established by UK Meds, there remains a distinct and parallel professional duty on the PIP, who has to exercise independent clinical judgment as to whether or not to prescribe.*

e. The Registrant had an important role as Clinical Lead and an overview of and some responsibility for the methodology employed.

f. *The extent of risk is not hypothetical, as demonstrated by allegations 7-10. Although it is not part of the GPhC's case that the prescriptions that the Registrant issued to Patients 2 and/or 13 were directly causative of their deaths, those cases demonstrate that the failures identified are capable of contributing to real life tragic outcomes.*

g. *the speed of the Registrant's personal prescribing practise further increased risk of inappropriate and unsafe prescribing.*

149. Mr Hoskins submitted that the Registrant's misconduct was aggravated by not reading the guidance to which he was subject. He submitted that the Committee had found that the Registrant's insight was incomplete and "fragile" despite the passage of time.

150. He acknowledged that the Registrant was not motivated directly by financial gain beyond keeping his job, that this was not a case of an abuse of a position of trust, and that the Registrant had cooperated with the investigation and demonstrated remorse. He had put forward supportive testimonials. He acknowledged that there were no previous disciplinary concerns recorded against the Registrant.

151. Mr Hoskins addressed each of the available sanctions in turn. He submitted that neither taking no action, giving advice or giving a warning would be sufficient to address the risk to the public which the Committee had identified. Nor would these sanctions be sufficient to address the wider public interest in maintaining public confidence in the profession or upholding standards of conduct for the profession.

152. Mr Hoskins submitted that conditions would not be appropriate because the Registrant's misconduct was too wide-ranging to be addressed by any workable conditions and conditions would not address the wider the public interest in maintaining public confidence in the profession and upholding standards of conduct.

153. Mr Hoskins submitted that suspension was not a sufficient sanction in this case having regard to the Registrant's late admissions and incomplete insight.

154. Mr Hoskins submitted that in all the circumstances the Registrant's misconduct was fundamentally incompatible with remaining on the register of pharmacists and that the appropriate sanction was removal.

155. Ms Maudsley reminded the Committee of the importance of imposing a proportionate sanction, that is one which is no more restrictive than is necessary to address the risk presented by the Registrant to the public and the wider public interest.

156. She reminded the Committee that the Registrant had engaged in extensive reflection and expressed his remorse and regret for not having approached his work at UK Meds with greater diligence. She submitted that the Registrant had raised matters with the Superintendent pharmacist but been too easily persuaded.

157. She reminded the Committee that the Registrant had undertaken extensive CPD and work with Dr DR which the Committee had found had reduced the risk of repetition significantly. She also reminded the Committee of the testimonial from the GP practise where the Registrant was currently working which spoke highly of his work and contribution to the practise. She submitted that it would not be in the public interest to deprive the public of the work of the Registrant.

158. Ms Maudsley submitted that there were a number of important mitigating factors in this case including the Registrant's full admissions the fact that he had made no financial gain beyond a relatively modest salary, the pressure of the COVID-19 pandemic and the fact that there had been no repetition of his misconduct since he left UK Meds.

159. Addressing the issue of proportionality, Ms Maudsley reminded the Committee of the financial hardship that would be caused to the Registrant by stopping him practise. She submitted that the Registrant had demonstrated he could comply with conditions and the Committee had acknowledged that he had made progress during the time that he was working subject to conditions. She submitted that in all the circumstances a further period of conditions would be the appropriate sanction because it would allow the Registrant to continue his remediation while serving the public.

The Committee's decision

160. At the outset of its discussions, the Committee identified the following aggravating Factors:

a. The Registrant's misconduct lasted for over two, and nearly three years despite him being alerted to failings in the UK Meds prescribing model;

b. The number of prescriptions that the Registrant issued;

c. The fact that the Registrant's misconduct put patients at risk of harm;

d. The Registrant occupied a supervisory role for part of his employment and did not act to prevent bad practise.

161. The Committee also identified the following mitigating factors.

a. The Registrant engaged with the regulatory process throughout including engaging in significant reflection and remediation.

b. The Registrant made full admissions to the Committee and the Committee found him to be a candid witness who faced up to his own responsibility, albeit in some cases belatedly;

c. The Registrant has demonstrated significant remorse and apologised for his actions, in particular where patients were affected;

d. The Committee does not wish to over emphasise the importance of the Registrant's good character because it expects that of a registered professional. Nevertheless, the Committee concluded that it is important that the Registrant has no previous regulatory findings recorded against him; that the Registrant practised for a number of years before he joined UK Meds and made a favourable impression upon those he worked with and he has worked as a pharmacist prescriber within a GP practice for two years since his misconduct and has continued to make a favourable impression upon his colleagues.

162. The Committee balanced the aggravating and mitigating factors and concluded that the aggravating factors outweighed the mitigating factors and the Registrant's misconduct must be viewed as serious. Nevertheless, the Committee observed that it did not fall into one of the categories identified in the guidance as the most serious forms of misconduct and the Committee has already found that the misconduct is remediable, and the Registrant has taken significant steps towards remediation.

163. The Committee then considered each of the available sanctions in turn.

164. The Committee concluded that there was no real doubt that neither taking no action, giving advice or giving a warning would be sufficient to address the risk to the public which the Committee had identified. Nor would these sanctions be sufficient to address the wider public interest in maintaining public confidence in the profession or upholding standards of conduct for the profession.

165. The Committee then considered whether it would be sufficient to impose Conditions on the Registrants registration. The Committee reminded itself that the Registrant has worked subject to conditions for two years without repeating his misconduct and has engaged in significant remediation and reflection during that time.

166. The Committee acknowledged Ms Maudsley's submission that a further period subject to conditions would allow the Registrant to continue his remediation while serving the public. The Committee also concluded that it may well be possible to

draught appropriate conditions in light of the Registrant's conduct for over two years and the fact that, although his misconduct included a wide range of failings, it was limited to a period of time when he was working remotely and in isolation.

167. Nevertheless, the Committee reminded itself of its duty to impose a sanction which maintained public confidence in the profession and upheld proper standards of behaviour. The Committee concluded that the imposition of conditions would not fulfil this objective because it would not demonstrate sufficiently to the profession and the public that the Registrant's conduct was unacceptable.

168. The Committee then considered whether it would be sufficient to suspend the Registrant from practise for a period of time. The Committee reminded itself of the passage at 4.3 in the guidance indicating when suspension may be appropriate:

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.

169. Applying this test, the Committee was satisfied that a period of suspension would protect the public and could uphold the wider public interest in maintaining confidence in the profession while at the same time giving the Registrant the opportunity to continue his remediation and develop insight.

170. Nevertheless, the Committee then considered with particular care whether it was necessary to remove the Registrant from the register to maintain confidence in the profession and uphold standards of behaviour.

171. The Committee reminded itself of the passage in the Guidance at paragraph 4.3 setting out when removal may be necessary:

Removing a professional's registration is reserved for the most serious conduct. The Committee cannot choose this outcome in cases which relate solely to the professional's health. The Committee should consider this outcome when the

professional's behaviour is fundamentally incompatible with being a registered professional.

172. The Committee reminded itself of the finding it has already made regarding the seriousness of the Registrants misconduct. It also reminded itself of its finding that the misconduct was remediable and the Registrant had taken significant steps towards remediation. It also reminded itself that the Registrant had reflected on his misconduct and (belatedly) made full admissions to the Committee and accepted full responsibility for what he had done. The Committee observed this came at the end of a process of significant study and working at a high standard in a GP's practice for two years.

173. Taking all these matters together the Committee was satisfied that the Registrants misconduct, in the context of all he had done before and since, fell short of being fundamentally incompatible with continued registration.

174. For those reasons, the Committee concluded that a period of suspension was the appropriate and proportionate sanction in this case.

175. The Committee then considered the appropriate period to impose. The Committee concluded that a period of 12 months was necessary to demonstrate how seriously the Committee took the misconduct in this case and to send a message how close the Registrant had come to being removed from the register.

176. Accordingly, the Committee directs that the Registrants registration will be suspended for a period of 12 months.

177. The Registrant's suspension will be reviewed shortly before it expires. The Committee does not purport to bind a future reviewing Committee but wishes to assist the Registrant by noting that the Reviewing Committee is likely to be assisted by the following matters:

    a. The Registrant's continued engagement with the Council and his attendance at the review hearing;

b. Further written reflection on why the Registrant behaved as he did, the risks he created and how he will ensure that he does not create such risk in the future;

c. Evidence of him maintaining his knowledge through CPD and otherwise;

d. Testimonials from any work he has undertaken, paid or unpaid, which would assist the Committee to assess his continued good behaviour;

e. Evidence of the Registrant's plans for the future.

Interim Order

178. After the Committee announced its decision on sanction, Mr Hoskins made an application for an interim measure of suspension to be imposed on the Registrant's registration, pursuant to Article 60 of the Pharmacy Order 2010 (the Order), pending the coming into force of the Committee's substantive order.

179. He reminded the Committee that the sanction it had imposed would not come into force for 28 days at the earliest and, if the Registrant appealed the Committee's decision, the Committee's sanction would not come into force until the appeal had been dealt with.

180. He submitted that, in light of the sanction imposed by the Committee, the interim measures could only be immediate suspension.

181. He submitted that interim suspension was necessary to protect the public and in the public interest and drew the Committee's attention to paragraph 170 of the Committee's decision in which the Committee said:

Applying this test, the Committee was satisfied that a period of suspension would protect the public and could uphold the wider public interest in maintaining confidence in the profession while at the same time giving the Registrant the opportunity to continue his remediation and develop insight.

182. Ms Maudsley submitted that no order was necessary in this case and risked causing injustice to the Registrant if he appealed the Committee's decision.

183. Ms Maudsley reminded the Committee of paragraphs 162 and 174 of its decision, in which it had found that the Registrant had worked "at a high standard in a GP practice" without repetition of his misconduct, while awaiting this hearing

184. The Committee had regard to Article 60 of the order which provides:

"If the Fitness to Practise Committee is satisfied that to do so is necessary for the protection of members of the public or is otherwise in the public interest or in the interests of the Registrant, it may order that the entry of the Registrant who is the subject of the direction in the part or parts of the Register to which the direction relates be suspended forthwith, pending the coming into force of the direction."

185. The Committee also had regard to the following paragraphs of the Guidance

3.3. A Committee may impose interim measures if it is satisfied that they are necessary to protect the public or are otherwise in the public interest or in the interests of the Registrant. Any interim measures will take effect immediately and can cover the 28-day 'appeal period'. If the Registrant appeals against the decision, they will stay in force until that appeal is decided.

3.4. Interim measures in the form of a suspension, may be imposed only if the Committee has decided to suspend the professional or remove them from the register. Interim conditions on the professional's entry in the register may only be imposed if the Committee's decision is to impose conditions.

186. The Committee reminded itself that it had a discretion whether to impose interim measures and could only do so if it was satisfied that, in this case, an interim measure of suspension was necessary to protect members of the public or in the public interest.

187. The Committee reminded itself that it had already found that a suspension order was necessary to protect the public and in the wider public interest.

188. The Committee also reminded itself that, although the Registrant had been working safely under conditions, the Committee was now obliged to revoke those conditions so that the Registrant would be working without any restriction until the Committee's sanction came into force, unless interim measures were put in place.

189. The Committee found that, in those circumstances, an interim order was necessary to protect the public and also to maintain public confidence in the profession. It was satisfied that an informed member of the public would be shocked if the Registrant could return to unrestricted practice following the Committee's decision.

190. The period of suspension will cover the 28 days until the direction to suspend the Registrants' name from the Register comes into effect and, if the Registrant appeals, will continue until the appeal is disposed of.

191. The period of suspension will cover the 28 days until the direction to suspend the Registrants' name from the Register comes into effect and, if the Registrant appeals, will continue until the appeal is disposed of.

192. The Committee were informed that an interim conditions order has been in in place since 8 March 2023

193. The Committee exercised its power under Rule 31 (16) of the rules, to revoke that order in accordance with article 56(10) of the Order.

194. That concludes the determination.