General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote videolink hearing

25 – 28 February 2025, 3 March 2025

Registrant 1 name:	Mr Simon Addison Smith
Registrant 2 name:	Mr Trishul Patel
Registration number 1:	2024372
Registration number 2:	2058183
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Ms Rachel Forster (Chair) Mr Jignesh Patel (Registrant member) Ms Joanna Bower (Lay member)
Legal Adviser:	Ms Morag Rea (Ms Debi Gould 28 February)
Committee Secretary:	Ms Ivana Raimundova
Registrant 1:	Not Present and not represented
Registrant 2:	Present and represented by Mr Tim Haines
General Pharmaceutical Council:	Represented by Gareth Thomas Case Presenter
Facts proved Registrant 1:	1-1.5, 2-2.5 ,3-3.5,3.8-3.9
Facts proved by admission Registrant 2:	1-1.3, 2-2.6
Facts not proved Registrant 1:	3.6 and 3.7
Fitness to practise Registrant 1:	Impaired
Fitness to practise Registrant 2:	Impaired

Outcome:

Registrant 1:	Suspension for 12 months
Registrant 2:	Warning
Interim measures registrant 1:	Interim suspension Order

Particulars of Allegation (as amended) against Registrant 1, Mr Simon Addison Smith

You, a registered pharmacist, and as Superintendent Pharmacist of Cannabliss, 15 Cannon Street, Preston, Lancashire, PR1 3NR ("the pharmacy"), between 1 February 2021 and 10 May 2022 failed to ensure that "the keeping, preparing and dispensing of medicinal products other than medicinal products on a general sale list [was] under [your] management" in that:

1. You allowed the pharmacy to operate without having in place adequate governance and safeguards in that

1.1. the pharmacy did not have a risk assessment in place for the services it provided; **PROVED**

1.2. the pharmacy did not maintain records to provide assurance that the Cannabis Based Medicinal Products (CBPM) it supplied had been appropriately prescribed; **PROVED**

1.3. the pharmacy supplied high-risk medicines to people who may be vulnerable in circumstances where no safeguarding procedures or training had been put in place; **PROVED**

1.4. a company Director, who is not a registered pharmacy professional and/or was untrained, was found to be working alone in the pharmacy on 10 May 2022; **PROVED**

1.5. a number of dispensing labels were found, which had not been attached to a medicine, but had already been signed by a dispenser and pharmacist; PROVED

2. Failed to ensure that the pharmacy was compliant with The Medicines Act 1968, The Health Act 2006 and The Medicines (Pharmacies) (Responsible Pharmacist) Regulations 2008, in that:

2.1. the pharmacy regularly operated without a Responsible Pharmacist being present and/or signed into the Responsible Pharmacist log (pharmacy record); **PROVED**

2.2. the Responsible Pharmacist log contained only 9 entries; **PROVED**

2.3. some of the entries in the Responsible Pharmacist log spanned weeks, with no absences recorded; **PROVED**

2.4. on 1 March 2022 and 15 February 2022, the record entry in the Responsible Pharmacist log did not include a time that responsibility ceased; PROVED

2.5. the Private Prescription register showed 40 of 167 records when no Responsible Pharmacist was recorded as being in charge of the pharmacy; **PROVED**

3. Failed to ensure that Controlled Drugs (CD's) were managed safely and/or in accordance with The Misuse of Drugs Act 1971 and The Misuse of Drugs Regulations 2001, in that:

3.1. 96 of the 212 'supplied' entries in the CD register had 'late entry' noted; **PROVED**

3.2. 18 of the 59 'received' entries in the CD register had 'late entry' noted; **PROVED**

3.3. 39 out of 212 records in the CD register recorded a date of supply on dates when there was no Responsible Pharmacist in charge of the pharmacy and/or signed into the Responsible Pharmacist log; **PROVED**

3.4. All of the entries in the CD register for between 8 March 2022 to 10 May 2022 had been made by the unregistered and/or untrained company Director; **PROVED**

3.5. three records in the CD register did not have a corresponding record in the private prescription register; patient A, patient B and patient C; **PROVED**

3.6. there are three duplicate entries in the CD register; patient H, Patient I and Patient J; **NOT PROVED**

3.7. Four records in the prescription register did not have corresponding entry in the CD register, those entries with ID 110, 159, 172 and 195; **NOT PROVED**

3.8. Five patients were identified as having received prescriptions from two different prescribing services, but there are no records to indicate that these had been challenged; Patient A, Patient D, Patient E, Patient F and Patient G; **PROVED**

3.9. CBPMs and Schedule 2 CD were not stored in a CD cabinet; **PROVED**

Particulars of Allegation against Registrant 2, Mr Trishul Patel

You, a registered pharmacist, and on occasion Responsible Pharmacist at Cannabliss, 15 Cannon Street, Preston, Lancashire, PR1 3NR ("the Pharmacy"), between March 2022 and April 2022:

1. Operated the pharmacy without having adequate governance and safeguards in place, in that:

    1.1. the Pharmacy did not have a risk assessment in place for the services it provided; **ADMITTED AND FOUND PROVED**

    1.2. the Pharmacy did not maintain records to provide assurance that the Cannabis Based Medicinal Products (CBPM) it supplied and / or dispensed had been appropriately prescribed; **ADMITTED AND FOUND PROVED**

    1.3. the Pharmacy supplied high-risk medicines to people who may be vulnerable in circumstances where no safeguarding procedures or training had been in place; **ADMITTED AND FOUND PROVED**

2. Failed to ensure that the Responsible Pharmacist log (pharmacy record) was maintained in that:

    2.1. your period of responsibility commencing on 1 March 2022 at 18:18 did not record a time when your responsibility ceased; **ADMITTED AND FOUND** PROVED

    2.2. your period of responsibility commencing on 9 March 2022 at 13:06 was recorded to have ceased on 11 March 2022 at 09:30, without your absences and / or reason for absence being recorded; **ADMITTED AND FOUND PROVED**

2.3. your period of responsibility commencing on 14 March 2022 at 13:31 was recorded to have ceased on 17 March 2022 at 15:00, without your absences and / or reason for absence being recorded; **ADMITTED AND FOUND PROVED**

2.4. your first period of responsibility on 17 March 2022 was recorded as commencing and ceasing at the same time, at 15:10; **ADMITTED AND FOUND PROVED**

2.5. your period of responsibility commencing on 17 March 2022 at 18:57 was recorded to have ceased on 29 March 2022 at 18:25, without your absences and / or reason for absence being recorded; **ADMITTED AND FOUND PROVED**

2.6. your period of responsibility commencing on 1 April 2022 at 09:53 was recorded to have ceased on 26 April 2022 at 12:19, without your absences and / or reason for absence being recorded; **ADMITTED AND FOUND PROVED**

Documentation

Document 1- Council's hearing bundle and Annexe

Document 2- Council's skeleton argument

Document 3- Council's Evidence Matrix

Document 4- Registrant 2's bundle

Document 5 – Registrant 2's skeleton argument

Document 6 – Proof of Service bundle

Document 7-Proceeding in absence bundle

Document 8- Joinder Application bundle

Document 9- Email dated 16 June 2023 from the Case Officer Ms 1 to Registrant 1 attaching an invitation to respond to allegations (dated 15 June 2023).

Witnesses

Mr 1, GPhC Inspector gave evidence at facts stage

Ms 1, GPhC Case Officer- gave evidence at facts stage

Mr Trishul Patel – gave evidence at Impairment stage

Determination

Introduction

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

2. This 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 ('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.

Conflict of Interest

6. Mr Thomas, the Case Presenter, raised that he recognised the Lay Committee member as a previous colleague from a Law firm in which they had both worked, albeit in different departments, some years ago. He did not believe there was a conflict of interest. The Chair asked Mr Haines for his views on behalf of Registrant 2. Mr Haines did not consider that this was a conflict which could impact the fairness of the proceedings. The Committee sought clarification about the circumstances from the Committee member. The Committee member had ceased working at that firm five years ago and had not worked in the same department as the Case Presenter nor had she ever worked with him. The Lay member did not believe there to be a conflict in her continuing to sit as a Committee member. The two other Committee members then retired to consider whether the participation of the Committee member concerned was a conflict or created the perception of a conflict. The Committee decided that there was no conflict of interest or perception of a conflict, and that the Committee as constituted could conduct a fair hearing.

Service of Notice of Hearing

7. The Committee has seen a letter dated 28 January 2025 from the Council headed 'Notice of Hearing' addressed to each of the Registrants and sent to their registered

email address as noted on the Register. No issue was taken in respect of service by either party.

8. The Committee took particular care to consider the service bundle in respect of Registrant 1, Mr Smith, who was not present nor represented. They had regard to the bundle of service evidence produced by the Hearing Secretary and noted that the Registrant had been explicit that he had received Notice but that he chose not to attend the hearing. He had corresponded with both the Hearing Secretary and the Case Presenter in this regard.

9. The Committee was satisfied that there had been good service of the Notice of Hearing ('Notice') in accordance with Rules 3 and 16 of the Rules in respect of both Registrants.

Application to proceed in the absence of Registrant 1

10. Registrant 1 was not in attendance at this hearing, nor did he have someone attending on his behalf. The Committee heard submissions from Mr Thomas, on behalf of the Council to proceed in the absence of Registrant 1 under Rule 25.

11. The Committee noted the correspondence from Registrant 1 which stated that while they accepted responsibility for the failings, that they would not be attending the proceedings.

12. The Committee accepted the advice of the Legal Adviser and considered the criteria set out in R v Jones 2002UKHL 5, and the proper approach identified in GMC v Adeogba and GMC v Visvadis [2016] EWCA Civ 162. for regulatory proceedings, bearing in mind the framework provided by the procedural rules articulated in Stewart v GPHC, 11 August 2017 unreported.

13. When a registrant is absent from a hearing, and not represented, the Committee may nevertheless proceed with the hearing if it is satisfied that (a) service of the Notice of Hearing has been properly effected, or (b) all reasonable efforts have been made to serve the registrant with the Notice (Rule 25 of the 2010 Order).

14. The Committee therefore has a discretion to determine that the hearing proceed in the absence of Registrant 1. The Committee should approach its consideration of the application with great care and caution. The Committee was reminded that a registrant who is facing a fitness to practise allegation has the right to be present and be represented at a hearing. However, the rules provide that, if a registrant is neither present nor represented at a hearing, the Committee has the discretion to proceed if it is satisfied that all reasonable steps have been taken to serve notice of the hearing on the registrant and that it is fair to do so in the circumstances of the case.

15. In exercising the discretion to proceed in absence, Committees must strike a balance between fairness to the registrant and fairness to the wider public interest, ensuring that there is adequate focus on public protection. Fairness to the registrant is of prime importance, but the overarching statutory objective of regulation is to protect the public.

16. The Committee decided to proceed in the absence of Registrant 1 for the following reasons:

- The Committee has found good service of the Notice; therefore Registrant 1 is, or should be, aware of today's proceedings. The Committee have therefore considered that Registrant 1 has chosen to voluntarily absent himslef from this hearing.

- Email correspondence from Registrant 1 dated 19 December 2024 indicated that he would not be in attendance at this hearing, and he did not ask for an adjournment. In his email correspondence of that date, Registrant 1 said he had nothing to input to the proceedings and that he was content for the hearing to proceed in his absence.

- The Council, through the Case Presenter contacted Registrant 1 regarding this hearing via email and Registrant 1 responded on 29 January 2025 to say that he would not be attending. He further stated:

"*I have no intention of renewing nor ever practicing as a pharmacist again! A fitness to practice hearing to me seems a total waste of valuable time given my capitulation and admission of failings. Mr Patel really should not in my opinion be held responsible for any of my or the companies failings"*

- There was no information to suggest an adjournment would result in Registrant 1's attendance in future.
- There is a public interest in the expeditious disposal of cases.
- Not proceeding today would inconvenience witnesses who are ready to give evidence.
- Not proceeding today would be unfair to Registrant 2, Mr Patel who is joined in this case.

Application to amend the particulars of allegation

The Committee heard an application from the Case Presenter under Rule 41 to amend the preamble in respect of the allegation against Registrant 1 to remove the three words "so far as" in order to improve the grammatical sense of the paragraph as follows:

You, a registered pharmacist, and as Superintendent Pharmacist of Cannabliss, 15 Cannon Street, Preston, Lancashire, PR1 3NR ("the pharmacy"), between 1 February 2021 and 10 May 2022 failed to ensure that ~~so far as~~ "the keeping, preparing and dispensing of medicinal products other than medicinal products on a general sale list [was] under [your] management" in that:

17. Registrant 1 was unrepresented and not present so could neither agree nor oppose the proposed amendments.

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

19. The Committee was of the view, having heard the Case Presenter's submissions, that the amendment was not material and would not alter the substance of the allegation faced by

Registrant 1. The Committee did not consider that it would prejudice Registrant 1's position. The Committee therefore allowed the amendment.

Registrants' response to Particulars of allegation

20. Registrant 1 responded on 27 June 2023 to the allegations sent by Case Officer Ms 1 dated 15 June 2023 with a general unspecified admission to all the conduct. These allegations were substantially the same as currently drafted. He stated:

"I am appalled that I have allowed the Pharmacy to operate without adequate governance and safeguards in place and I am not going to try to defend the failings described in the allegations. …

I accept that I obviously did not have the necessary skills to fulfil that role or give sufficient attention to my responsibilities"

21. Registrant 2, through his representative, admitted every particular of the allegation.

22. In the light of the above, and by the application of Rule 31(6) of the Rules, the admitted factual particulars were found proved in respect of Registrant 2.

23. In respect of Registrant 2, the Committee will go on to consider, at the next stage of the proceedings, whether Registrant 2's fitness to practise is currently impaired which is a matter for the Committee's judgement.

24. The Committee went on to receive evidence and submissions regarding the particulars of the allegation against Registrant 1.

Background

25. On 12 February 2025, on application of the Council, the two cases were joined for a Principal Hearing. A joinder bundle was served on both Registrants on 29 January 2025.

26. Both Registrants face allegations that their fitness to practise is impaired by reason of their misconduct. The allegations relate to their respective roles at the same

Pharmacy, which traded as 'Cannabliss', and in relation to the same set of concerns: that the operating model and record keeping at the Pharmacy were non-compliant and unsafe. The Pharmacy was supplying Cannabis Based Medicinal Products (CBMP) against private prescriptions received from doctors who were on a specialist register. Registrant 1 was the Superintendent and the Responsible Pharmacist (RP) on occasions, Registrant 2 was the RP on a number of occasions. The roles of Superintendent and RP are set out in statute and regulations.

27. On 10 May 2022, the Pharmacy was visited by Mr 1, a GPhC Inspector, as part of a (routine) first pharmacy inspection ('the Inspection') following the Pharmacy's registration. Several concerns were identified by the Inspector in relation to the running of the Pharmacy, the management of controlled drugs, and the keeping of records. At the time of the Inspection, an untrained company director was working alone at the Pharmacy, and no RP was present on that date.

28. A copy of the Responsible Pharmacist (RP) log was obtained. It contains only 9 entries between the dates 11 February 2022 and 1 April 2022 (the Inspection was in May 2022). Mr Smith was recorded as the RP on 3 occasions and Mr Patel on 6 occasions.

29. After the Inspection, Conditions were imposed on the Pharmacy that it must not obtain or supply any controlled drugs within Schedules 1-5 of the Misuse of Drugs Regulations 2001 (as amended).

Decision on Facts

30. In reaching its decisions on facts, the Committee considered the documentation listed at the start of this determination, the oral evidence of Mr 1 and Ms 1 and the submissions made by the Council.

31. Mr 1 adopted his statements as his evidence in chief but provided further oral evidence in respect of the background to the Inspection and to the nature of the Pharmacy business of Cannabliss.

32. His evidence was that the business had been registered with the GPhC on 1 February 2021 but had not begun trading until many months later. He had made an inspection visit in July 2021 and the business was still not trading. He subsequently had contacted the Director by telephone and had been informed when the Pharmacy had started trading. A few months thereafter, on 10 May 2022, he made an inspection visit to the Pharmacy. His evidence was that his practice was to allow a business to operate for a 'handful of months' before making an unannounced visit. He produced the records for the Pharmacy during that inspection, which dated back to 1 February 2022. Mr 1 noted that the Pharmacy provided a service dispensing CBMP which are categorised as Schedule 2 controlled drugs and are only available on prescription in specific circumstances and for specific medical conditions. He explained that the process of supplying CBMP is strictly controlled, and CBMP can only be prescribed by a doctor on a specialist register. He noted that some CBMP dispensed at the Pharmacy were unlicensed and therefore required very close control and record keeping.

33. Ms 1 confirmed that as Case Officer she had performed the redactions on the screen shots of the documents uplifted from the Pharmacy computer records. She confirmed in answer to questions from the Committee that the dates that she had used in identifying repeated supply dates of CBMP were from the first column of the Controlled Drug Register, which was the date that the supply had been entered onto the register. She confirmed that she had not used the dates from the fourth column of the Controlled Drugs Register, which identified that these entries were late entries, and showed that the drugs had in fact been supplied at an earlier date.

34. 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.

Particular 1

35. 1.In respect of the preamble to particular 1, the Committee accepted the oral evidence of the Inspector in respect of the delay in the Pharmacy starting to trade.

Taking into account the date of the records uplifted and exhibited, the Committee determined that the date on which it saw evidence that the alleged conduct began was 1 February 2022, and not 1 February 2021 (which was the date that the Pharmacy was registered). The Committee therefore found that the allegations fall between 1 February 2022 and 10 May 2022.

1.1*. the pharmacy did not have a risk assessment in place for the services it provided.*
The Committee took into account the oral evidence of the Inspector and his inspection report. The Committee was of the view that this was cogent contemporaneous evidence and accepted that a risk assessment would have been sought by the Inspector and provided, should it have existed. The Committee also took into account the general admission of Registrant 1, in response to the allegations he submitted on 23 June 2023, that he 'failed miserably to ensure that the Pharmacy was run safely and in compliance with the regulations'. This particular is found proved.

1.2. *the pharmacy did not maintain records to provide assurance that the Cannabis Based Medicinal Products (CBPM) it supplied had been appropriately prescribed.*
The Committee took into account the oral evidence of the Inspector, the Inspection report produced following the Inspection on 10 May 2022, and the records exhibited, to identify the failings which the Inspector had identified in respect of Standard 4.2 (Services, including medicines management). This particular is found proved.

1.3. *the pharmacy supplied high-risk medicines to people who may be vulnerable in circumstances where no safeguarding procedures or training had been put in place.*
The Committee took into account the oral evidence of the Inspector and his report in

respect of Standard 1.8 (Governance) where he noted that the Pharmacy 'does not have any safeguarding procedures or training in place'. The Committee also took into account Registrant 1's response to allegations in which he accepted that he had allowed the Pharmacy to operate without adequate safeguards in place and was 'not going to try to defend the failings described in the allegations'. This particular is found proved.

1.4. *a company Director, who is not a registered pharmacy professional and/or was untrained, was found to be working alone in the pharmacy on 10 May 2022.*

The Committee took into account the evidence of the Inspector that the company director was the only person in attendance at the Pharmacy on 10 May 2022 during the Inspection and determined on the evidence that the company director was not registered and was working alone. This particular is found proved.

1.5. *a number of dispensing labels were found, which had not been attached to a medicine, but had already been signed by a dispenser and pharmacist.*

The Committee considered that a photograph exhibited clearly identified that a dispensing label for a prescription had been printed and was signed in the 'dispensed by' and 'checked by' boxes but was not attached to a product. The Committee was persuaded by the compelling oral evidence of the Inspector on this issue. This particular is found proved.

Particular 2

36. The Committee went on to consider Particular 2 which states that Registrant 1:

Failed to ensure that the pharmacy was compliant with The Medicines Act 1968, The Health Act 2006 and The Medicines (Pharmacies) (Responsible Pharmacist) Regulations 2008, in that:

2.1. *the pharmacy regularly operated without a Responsible Pharmacist being present and/or signed into the Responsible Pharmacist log (pharmacy record).*

The Committee has analysed the evidence of the Responsible Pharmacist (RP) log, the Private Prescriptions log and the CD Register and identified that these provided the evidence

that the Pharmacy was regularly open and operating on multiple without an RP being present, or when an RP had not signed in. This particular is found proved.

2.2. *the Responsible Pharmacist log contained only 9 entries.*

The Committee considered the RP log and found this fact proved on the face of the document. This particular is found proved.

2.3*. some of the entries in the Responsible Pharmacist log spanned weeks, with no absences recorded.* The Committee found evidence to prove this on the face of the log. This particular is found proved.

2.4. *on 1 March 2022 and 15 February 2022, the record entry in the Responsible Pharmacist log did not include a time that responsibility ceased.*

The Committee accepted the evidence of the log as exhibited. This particular is found proved.

2.5. *the Private Prescription register showed 40 of 167 records when no Responsible Pharmacist was recorded as being in charge of the pharmacy.*

The Committee carefully analysed the Private Prescription register and the RP log, comparing the dates of records and identified at least 40 entries recorded when no RP was in charge of the pharmacy. This particular is found proved.

Particular 3

37. The Committee went on to consider allegation 3 which states that Registrant 1: *Failed to ensure that Controlled Drugs (CD's) were managed safely and/or in accordance with The Misuse of Drugs Act 1971 and The Misuse of Drugs Regulations 2001, in that:*

3.1. *96 of the 212 'supplied' entries in the CD register had 'late entry' noted.*

The Committee accepted the evidence of the Inspector that a couple of late entries, or entries made the following day would be within tolerance. The Committee accepted the Inspector's evidence that the volume of late entries would be regarded as ' a massive red flag'. The Committee considered the CD register in detail and identified 96 red flags which were late entries against supplied entries. This particular is found proved.

3.2. *18 of the 59 'received' entries in the CD register had 'late entry' noted.*

The Committee considered the CD register in detail and identified at least 18 late entries which were recorded against received entries, and so this particular is found proved.

3.3. *39 out of 212 records in the CD register recorded a date of supply on dates when there was no Responsible Pharmacist in charge of the pharmacy and/or signed into the Responsible Pharmacist log.* The Committee made a careful analysis of the information recorded in the CD register and found that at least 39 instances in which this was the case. This particular is found proved.

3.4. *All of the entries in the CD register for between 8 March 2022 to 10 May 2022 had been made by the unregistered and/or untrained company Director.*

The Committee took into account the Inspector's report, the Inspector's statements and his oral evidence and the CD register entries and RP log and found this particular proved.

3.5. *three records in the CD register did not have a corresponding record in the private prescription register; patient A, patient B and patient C*.

The Committee accepted the evidence of the Inspector that while legally this was not a requirement, it was nonetheless considered good practice to do so. The Inspector noted that it was the Pharmacy's practice to record in this way but not always consistently. The Committee noted Patients A, B and C had entries in the CD register on 22 April 2022 but there were no records of any medication supplied on the Private Prescriptions records for that day. The Committee found that this particular is proved.

3.6. *there are three duplicate entries in the CD register; patient H, Patient I and Patient J.*

The Committee carefully considered the redacted screen shots of the CD register. The Committee also took into account the oral evidence of the Inspector who stated that from these exhibits, it was not possible to identify the duplications because of the redactions of the patient names. Therefore this particular is not proved.

3.7. *Four records in the prescription register did not have corresponding entry in the CD register, those entries with ID 110, 159, 172 and 195.*

The Committee considered that while this is referred to in the Inspection report, it was not able to verify the particular ID references, given the extent of redactions in the CD register. The Committee also took into account the Inspector's evidence who stated that from these exhibits it was not possible to identify the duplications because of the redactions. This particular is not proved.

3.8. *Five patients were identified as having received prescriptions from two different prescribing services, but there are no records to indicate that these had been challenged; Patient A, Patient D, Patient E, Patient F and Patient G.*

The Committee considered the Inspector's report, his witness statement and oral evidence and accepted that he had identified no evidence of any challenge to a prescribing service. Furthermore there was no evidence of any systems in place for checking and challenging instances in which there had been different prescribing services. The Committee accepted the evidence of the Case Officer, Ms 1, that she had redacted the documents after she had identified the different prescribing services. This particular is found proved.

3.9. *CBPMs and Schedule 2 CD were not stored in a CD cabinet.*

The Committee took into account the evidence of the Inspector and accepted that this was what he saw when he undertook his inspection. The Committee also noted the response of Registrant 1 when he said that ' I have obviously failed miserably to ensure that the Pharmacy was run safely in compliance with the regulations'. This particular is found proved.

Misconduct

Misconduct Having found some particulars of allegation proved against Registrant 1 and all of the allegations proved against Registrant 2, the Committee went on to consider whether the particulars found proved amounted to misconduct and, if so, whether each of the Registrants' fitness to practise is currently impaired.

38. The Committee took account of the Guidance given to the meaning of 'fitness to practise'. Paragraph 2.12 reads:

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

pharmacist…safely and effectively. In practical terms, this means maintaining appropriate standards of competence, demonstrating good character, and also adhering to the principles of good practice set out in our various standards, guidance and advice."

39. The Committee took into account the submissions made by Mr Thomas and Mr Haines. It also heard evidence from Mr Trishul Patel.

40. Mr Thomas submitted that the essence of the wrongdoing is that the Pharmacy was handling controlled drugs, CBMP, but much of the operation was apparently left to an unregulated individual while those Pharmacists responsible failed to ensure that record keeping was compliant or that risks were adequately assessed and managed.

41. Mr Thomas submitted that the handling and dispensing of cannabis-based products by pharmacists calls for special care. In fact, basic principles of pharmacy practice were not being observed at the Pharmacy and the Registrants (despite being in leadership roles) failed to ensure compliance. Their behaviour would be regarded with opprobrium and is sufficiently serious to meet the threshold for serious professional misconduct. On behalf of the Council he submitted that the conduct breached Professional Standards 5 and 9, as set out in Standards for Pharmacy Professionals (2017).

42. Mr Thomas submitted that the factors in Rule 5(2)(a) to (c) are engaged. Both Registrants displayed very poor professional judgement and failed in basic pharmacy practice to ensure compliance and proper record keeping in respect of unlicensed controlled drugs. He stated that these are fundamental errors that would tend to undermine public confidence in them and the pharmacy profession and could lead to patient harm. He submitted that both Registrants have accepted responsibility for their actions. Registrant 2 has provided substantial reflection and evidence of good character and remediation. Registrant 1 has provided his response to allegations and expressed remorse in correspondence with the GPhC. Mr Thomas submitted that neither Registrant has fully explained how such fundamental errors occurred in relation to CBMP or why what should have been

'red flags' did not alert them to the need for greater scrutiny of the arrangements. Mr Thomas submitted that a risk of repetition remains and the public interest in declaring and upholding standards requires a finding of impairment.

43. Registrant 2 did not accept that his actions amounted to misconduct and that his fitness to practise is currently impaired. Mr Haines submitted that whilst Registrant 2 could not concede the question of "misconduct", he did not make any representations suggesting that his conduct was anything but serious.

44. Mr Haines submitted that the conduct was remediable and had been remedied. He relied upon the evidence provided by Registrant 2 in his witness statement, his reflective statement and his oral evidence. He submitted that the events dated back nearly three years. He highlighted Registrant 2's remorse, his reflection and insight, his extensive CPD undertaken to remedy the deficiencies in his practice and how he has applied this learning. He submitted that there was no risk of repetition by Registrant 2 and that he was continuing to work as a pharmacy professional without any further issue. He submitted that in respect of the public interest, public confidence and upholding proper standards of the profession could be maintained in this case by the imposition of a warning, rather than by a finding of impairment.

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

Decision on misconduct

46. When considering whether the particulars found proved amounted to misconduct the Committee took into account the Guidance.

47. The Committee considered whether Registrant 1 had breached any of the Council's Standards for Pharmacy Professionals (May 2017). The Committee determined that there had been breaches of the Standards:

a. Standard 2: **Must work in partnership with others**

Registrant 1 did not take action to safeguard people, including…..vulnerable adults or make and use records of the care provided.

b. Standard 5: **Must use their professional judgement**

Registrant 1 showed poor judgement by involving himself in this specialist business, failing to ensure that safeguards were in place to manage risks and to comply with requirements to adequately document this process.

c. Standard 9: **Must demonstrate leadership**

Registrant 1 was the Superintendent of the Pharmacy and therefore in a position of clinical and regulatory leadership. However, he failed to work with colleagues effectively or set safe and compliant parameters within which others should work. Specifically, as Superintendent, Registrant 1 was required to oversee the business of the Pharmacy and ensure that proper processes were in place. In a business which only supplied CBMPs, he allowed the Pharmacy to operate without an RP at all on occasion, and with no RP in place for significant periods of time.

48 . The Committee considered whether Registrant 2 had breached any of the Council's Standards for Pharmacy Professionals (May 2017). The Committee determined that there had been breaches of the Standards:

a. Standard 2: **Must work in partnership with others**
Registrant 2 did not take action to safeguard people, particularly vulnerable adults, or make and use records of the care provided.

b. Standard 5 : **Must use their professional judgement**
Registrant 2 showed poor judgement by involving himself in this specialist business and by failing to ascertain that proper safeguards and procedures were in place to manage risks. Additionally, he failed to follow proper procedures as to documenting his attendance at the Pharmacy.

c. Standard 9: **Must demonstrate leadership**

Registrant 2, when working as an RP in the Pharmacy, was in a position of clinical and regulatory leadership but failed to work together with others in leadership to set and maintain safe and compliant parameters within which others should work.

49. The Committee bore in mind that the Standards may be taken into account when considering the issues of grounds and impairment but that a breach of the Standards does not automatically result in a finding of misconduct (Rule 24(11) of the Rules).

50. The Committee considered each Registrant in turn, independently from one another.

Registrant 1

51. The Committee decided that the facts found against Registrant I amounted to misconduct which was serious for the following reasons. The repeated failures in providing oversight to the Pharmacy over approximately a three-month period was in breach of the Standards. It would be considered a serious departure from those Standards by other professionals given the specialist nature of the business dispensing CBMPs. Registrant 1 had given no consideration of the extra safeguards required. He had allowed the Pharmacy to operate without the presence of an RP. He had not taken sufficient steps to check where there were duplicate prescribing services for the same patient, nor implement any processes for so doing. This creates a risk to patient safety. He did not ensure that CBPMs were stored in a CD cabinet. Additionally, he did not provide training or SOPs to ensure that colleagues knew how to correctly store and handle the CBMPs and that they did so.

52. Accordingly, the Committee concluded that, in its judgment, the ground of misconduct is established in respect of Registrant 1.

Registrant 2

53. The Committee decided that the facts found against Registrant 2 amounted to misconduct which was serious. The failures in governance, failure in care for patient safety and poor record keeping are in breach of the Standards and would be considered a serious departure from those Standards by other professionals, given the specialist nature of the business dispensing CBMPs. The Committee noted that Registrant 2's evidence was that he did not once access Patient Medication Records to check the prescribing history. He made assumptions about the qualifications and training of his colleague, the company director, thereby effectively absolving himself of any responsibility for the safe running of the Pharmacy. He failed to sign in and out of the RP Log appropriately. This rendered the important function of the RP Log void. His approach was casual, lacked professional curiosity and displayed seriously poor judgement.

54. The Committee therefore went on to consider whether the fitness to practise of each Registrant is impaired.

Decision on Impairment

55. Having found that the particulars of allegation amounted to misconduct, the Committee went on to consider whether each of the Registrant's fitness to practise is currently impaired. In doing so the Committee considered whether the particulars found proved show that actions / omissions of each Registrant:

- *present an actual or potential risk to patients or to the public;*
- *has brought, or might bring, the profession of pharmacy into disrepute;*
- *has breached one of the fundamental principles of the profession of pharmacy;*
- *means that the integrity of the registrant can no longer be relied upon.*

Registrant 1

56. The Committee found that while the circumstances leading to the findings above are remediable, there was no evidence of remediation from Registrant 1. The more serious the issue, the more difficult it may be to remediate, in particular, by upholding the wider public interest.

57. The Committee found that Registrant 1 has shown limited insight into the circumstances that led to the findings above. He apologised and acknowledged what had happened in general terms, and expressed remorse in his response to the allegations. However, Registrant 1 gave no explanation as to why it happened, or demonstrate that he understands the full impact of his failings on both patients and the wider public. Although there was no evidence of any actual harm to any patient, there was a significant risk of harm.

58. Registrant 1 has not remediated. He has taken no steps to prevent any repetition through reflective practice, CPD or other training.

59. The Committee therefore determined that there had been no remediation. The Committee was concerned that although Registrant 1 had accepted responsibility and apologised for his conduct, he did not have any insight into the full impact of that conduct. In his last correspondence with the GPhC, dated 29 January 2025, Registrant 1 stated:

"In my mind I have ceased to be registered as a Pharmacist and can't accepted (sic) responsibility for the failings. Cannabliss is no longer trading, the company is dissolved. Please advise as this feels like a pointless exercise, I am not doubting or diminishing the seriousness of the problems but what is the point?"

60. The Committee concluded that this showed a dismissive response to regulation and to the Fitness to Practise process.

61. In his response in 2025, Registrant 1 indicated his intention to come off the Register and cease to practise as a Pharmacy professional. In his response in 2023, however, he expressed a wish to remain on the Register. The Committee therefore concluded that his expressed intention to come off the Register was equivocal. Consequently, the Committee concluded that there is a risk of repetition. Given Registrant 1's lack

of reflection, absence of any real insight, and no remediation, there remains a real risk of repetition. Any risk of repetition carries with it a future risk to patient safety.

62. The Committee was particularly concerned by the Registrant's lack of explanation as to how and why such fundamental errors of judgment occurred, and failure to ensure that proper processes and procedures were set, maintained and followed.

63. The Committee determined that the wider public interest (protection of the public, maintaining public confidence and upholding professional standards) requires a finding of impairment. In addition to the future risk of harm, a finding of impairment is necessary to mark the seriousness of what has occurred. This is needed to maintain public confidence and promote professional standards, making clear to other professionals what is expected of them.

64. The Committee therefore finds Registrant 1's current fitness to practise to be impaired on all grounds. Accordingly, it went on to consider the issue of outcome.

Registrant 2

65. The Committee found that the circumstances leading to its findings of fact to be remediable.

66. Registrant 2 has demonstrated steps towards remediating his misconduct. He has also taken steps to prevent a repetition through reflective practice and extensive CPD. The Committee was presented with evidence that Registrant 2 had taken significant steps to improve his practice, and in particular setting alerts to remind him to make entries in the RP log. The Committee retains some concern that Registrant 2 is still unable to explain how his errors of judgment occurred, given his significant experience as a Pharmacist.

67. The Committee also took into account the testimonials and character references provided by Registrant 2's colleagues, and acknowledged that he had been entirely transparent about his conduct with them and with the Committee. Finally, the Committee took into account that Registrant 2 has been working as a Pharmacist for the last three years with no apparent concerns.

68. Having regard to the entire picture, the Committee concluded that the risk of repetition was very low and that Registrant 2 had remediated sufficiently in terms of public protection.

69. The Committee then considered whether the wider public interest (maintaining public confidence and upholding professional standards) requires a finding of impairment. It reminded itself that irrespective of any future risk of harm, a finding of impairment is sometimes necessary to mark the seriousness of what has occurred in order to maintain public confidence. The Committee determined that this is such a case. This is because of the nature of the products being supplied, the strict controls imposed on such products and the poor judgment shown by Registrant 2. The misconduct was only stopped by the GPhC investigation. A finding of impairment is therefore required to maintain public confidence and uphold proper professional standards.

70. The Committee therefore finds Registrant 2's current fitness to practise to be impaired on public interest grounds only. The Committee therefore went on to consider the issue of outcome.

Decision on Sanction

71. Having found impairment, the Committee went on to consider the appropriate outcome for each Registrant in turn. The Committee's powers are set out in Article 54(2) of the Order. The Committee should consider the available outcomes in ascending order from least restrictive (take no action), to most restrictive (removal from the Register), in order to identify the appropriate and proportionate outcome that meets the circumstances of the case.

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

73. The Committee had regard to the Guidance to inform its decision.

74. The Committee took into account the submissions made by Mr Thomas and Mr Haines.

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

76. The Committee considered each Registrant's case separately and independently of the other. The Committee noted, however, that both Registrants were involved with the same Pharmacy such that there is some overlap.

77. Mr Thomas submitted that the following aggravating factors were common to both Registrants:

- The business model of the Pharmacy was supplying CBMPs which requires a degree of special treatment, handling and management;

- Despite the Pharmacy's relatively short operating period, there were a significant number of patient supplies.

78. Mr Thomas submitted that the following mitigating factors applied to both Registrants:

- The operational trading period of the Pharmacy was a maximum of 4 months, albeit the allegations in respect of Registrant 2 span only one month;
- No harm was caused to any patient during the Pharmacy's operational trading period;
- In respect of each Registrant the period of misconduct represented a relatively short episode in what were otherwise unblemished careers.

79. Mr Thomas submitted that the real concern in the case of both Registrants, as the Committee had identified, was the lack of judgement each displayed in relation to their respective involvement in the Pharmacy. He reminded the Committee that Registrant 2 had not fully explained how or why this happened but that he had presented balancing evidence of good judgement and professionalism since the misconduct, which has won colleagues trust over the last 3 years. He had apologised and made admissions immediately and followed these with admissions in front of the Committee. By contrast, Mr Thomas submitted, Registrant 1 has not taken the opportunity, which that time has afforded him, to undertake any reflective or remedial work, although he has apologised for his misconduct.

80. Mr Haines submitted that there was a clear distinction between Registrant 1 and Registrant 2 because of the Committee's conclusion that Registrant 2's impairment was on public interest grounds only. He submitted that a Warning was a relevant, appropriate and proportionate outcome in respect of Registrant 2. In particular, Mr Haines reminded the Committee that there is a strong public interest in competent pharmacists being able to continue to practise where there is no risk to patient or public safety.

81. The Committee first considered the appropriate outcome in the case of Registrant 1. It began by identifying what, if any, aggravating and mitigating factors there may be in respect of him.

Registrant 1

82. The Committee identified the following aggravating factors:

a. The nature of the business model, supplying CBMPs;

b. The conduct was not an isolated incident but took place over a period of 3 -4 months;

c. The Registrant, as the Superintendent, had the primary responsibility for the safe governance of the Pharmacy;

d. The operation of the Pharmacy was left to an unqualified director, often with no RP on site;

e. Registrant 1 did not engage with the regulatory process in any meaningful way.

83. The Committee identified mitigating factors in respect of Registrant 1:

a. He apologised for his misconduct;
b. He had broadly accepted his failings;
c. He had not sought to blame Registrant 2 or others.

84. The Committee considered the following factors to be relevant to outcome. Registrant 1 disregarded the strict rules relating to the governance and safeguarding of CBMPs by allowing the Pharmacy to operate without a RP on duty on a number of occasions, by failing to put into place proper systems and processes for the safe operation of the Pharmacy and by delegating the overall running of the Pharmacy to an unqualified director.

85. Although no risks materialised and there was no evidence of harm to patients, there was a real risk of harm, including to people who may be vulnerable, which Registrant 1 did not appear to recognise or acknowledge. Registrant 1 did not engage with the regulatory process at all. His responses were flippant. His lack of engagement with his regulator demonstrated a flagrant disregard for the proper governance he knew was required in respect of the management and handling of CBMPs and the regulatory process.

86. The Committee concluded that Registrant 1 demonstrated a deep-seated attitudinal problem which he had not sought to remediate and in respect of which he showed little insight. The Committee therefore concluded that there was a real risk of repetition, and that Registrant 1 continues to present a risk to the safety of patients and the wider public.

87. The Committee also considered that given the importance of proper governance systems and management in respect of CBMPs, there is a strong public interest in declaring and maintaining appropriate standards for pharmacy professionals in order to maintain public confidence in the profession.

88. A finding of impairment having been made, the lowest outcome available to the Committee is to give a Warning. For the reasons set out above, having balanced the aggravating and mitigating features, the Committee concluded that a Warning is not a sufficient or appropriate outcome.

89. The Committee next considered the imposition of conditions of Registration.

90. Registrant 1 did not engage with or participate in the regulatory process. He stated an equivocal position in relation to whether he intended to remain in the profession. There is no evidence that he has undertaken any training or CPD or that he has practised pharmacy since this matter arose. In light of this, the Committee accepted the submissions of Mr Thomas that no relevant conditions could be formulated and that conditions were unworkable. Furthermore, the Committee was not satisfied that Registrant 1 would comply with any conditions imposed given his lack of engagement with the regulatory process to date.

91. The Committee next considered whether suspension would be a proportionate outcome. The Committee noted the Council's guidance which indicates that suspension may be appropriate where:

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

92. The Committee concluded that Registrant 1's fitness to practise is impaired on the grounds of public protection and public interest. The importance of ensuring that proper systems and processes are in place, are properly maintained and followed

when supplying medication, but particularly CBMPs cannot be understated. Such drugs need to be properly and carefully managed, handled and stored. Supply of CBMPs requires careful oversight, particularly in relation to prescription history, in order to protect the safety and wellbeing of patients.

93. The Committee considered this to be a serious case. The public would be shocked that CBMPs were being handled in this way and that Registrant 1 was aloof from the actual management of that risk. He was in a senior position but allowed Registrant 2 to act as an RP knowing that the Pharmacy was being run on a day-to-day basis by a Director who was not a pharmacy professional. The Committee therefore concluded, given the lack of governance demonstrated by Registrant 1 and his attitude concerning this, that public protection, the maintenance of proper professional standards and public confidence in the profession necessitated an Order of Suspension.

94. The Committee concluded that the proportionate period of suspension, bearing in mind the seriousness of the misconduct found proved, is 12 months. The Committee also considered that 12 months is sufficient time to enable Registrant 1 to start his journey of reflection, remediation and learning.

95. The Committee considered whether Registrant 1 should be removed from the Register. It concluded that although his misconduct was serious, it was not so serious as to require his removal. The misconduct related to matters of governance rather than clinical competence but did not reach the upper end of the scale as being so serious that it is fundamentally incompatible with being a registered professional. Suspension properly protects public safety and the wider public interest but allows Registrant 1, should he choose to engage, to remediate and demonstrate that he no longer presents any risk to patient safety or the wider public interest.

96. The Committee therefore directs that the Registrar suspend Registrant 1 from the Register for a period of 12 months.

Review Hearing

97. This decision to suspend Registrant 1 will be reviewed by a future committee before the outcome expires. A future committee may be assisted by:

- Evidence of training in relation to governance systems relating to the misconduct;
- Evidence of focused reflection on the following:
    - why Registrant 1 became involved with the Pharmacy
    - why he failed to exercise due diligence in relation to the existence of proper governance and safeguarding systems
    - why he did not ensure that the governance and safeguarding systems were operated and maintained when he acted as Superintendent of the Pharmacy.
- Evidence that Registrant 1 recognises and understands the importance of the regulatory process and the impact of his misconduct on patients and the wider public.

Registrant 2

98. The Committee identified the following aggravating factors:

a. The nature of the business model, supplying CBMPs and Registrant 2's lack of professional curiosity about governance and safeguarding procedures relating to CBMPs when he worked at the Pharmacy as a locum Registered Pharmacist;

b. The conduct was not an isolated incident but was repeated on 7-8 occasions.

99. The Committee identified some mitigating features in respect of Registrant 2 including:

a. Although repeated, his misconduct occurred over a relatively short time period;

b. He distanced himself from the Pharmacy once he became aware of the Inspection's concerns;

c. He apologised and showed remorse for his misconduct;

d. He accepted full responsibility and did not seek to blame others;

e. He engaged with the regulatory process from the outset and was co-operative with it;

f. He had made strenuous offers to remediate through reflection and training;

g. As a result, he had demonstrated his understanding of the importance of proper governance systems and processes and that he has continued to work as a pharmacist without any concerns over the three years prior to this hearing;

h. He previously had a long and unblemished career.

100. The Committee has already concluded that Registrant 2 does not present a danger to the public because of his insight and remediation. It determined that his fitness to practise is impaired on public interest grounds only. The Committee accepted Mr Haines' submissions that Registrant 2 had accepted responsibility for his failings from the outset, was embarrassed by them and that the regulatory process had had a deep and profound impact upon him.

101. Although Registrant 2 did not have overall responsibility for the operation of the Pharmacy, his role was an important one. He failed to apply proper or sufficient professional curiosity when exercising his role and then failed to be proactive in ensuring that the Pharmacy operated safely. He applied a casual approach to record keeping and reviewing patient prescription histories.

102. However, the Committee reminded itself of its findings that Registrant 2 had acknowledged and recognised the risk that his poor management practices presented to patients. Following the inspection, Registrant 2 distanced himself from the Pharmacy and took positive steps to address his failings, through reflection and relevant and appropriate CPD courses. He engaged fully with the regulatory process from the outset and has demonstrated his ability to work safely since.

103. Given the importance of proper governance systems and management in respect of CBMPs, there is a strong public interest in declaring and maintaining appropriate standards for pharmacy professionals in order to maintain public confidence in the profession. The Committee accepted Mr Haines' submission that a Warning against Registrant 2's name on the Register is a public acknowledgement that his conduct was unacceptable, was a serious error of judgement and demonstrates to the profession and the public the importance which this Committee attaches to such governance.

104. A finding of impairment having been made, the lowest outcome available to the Committee is to give a Warning. For the reasons set out above, having balanced the aggravating and mitigating features, the Committee concluded that an appropriate and proportionate outcome in relation to Registrant 2 was a Warning.

105. The Committee considered whether it would be appropriate to impose conditions of Registration on Registrant 2. The Committee reminded itself that it had not found Registrant 2's fitness to practise to be impaired on public safety grounds. It further reminded itself that no concerns had been raised about Registrant 2's clinical competence and that he had taken significant steps to address his misconduct. The Committee therefore accepted the submissions of Mr Thomas and Mr Haines that no relevant, workable conditions could be formulated. The Committee therefore concluded that conditions were not appropriate.

106. Having heard submissions from Mr Thomas, the Committee considered whether suspension would be a proportionate outcome. It noted that the Guidance states that suspension is an appropriate outcome where a registrant's *conduct "is unacceptable and unbefitting a member of the pharmacy profession" or "when public confidence in the profession demands no lesser outcome."*

107. The Committee concluded in this case that Registrant 2's actions demonstrated developing insight, that he had taken significant steps to remediate his misconduct and had minimised any risk of repetition. Taken together with Registrant 2's lesser role and involvement in the Pharmacy, the Committee concluded that public

confidence did not require suspension and that it would be disproportionate in the circumstances to make such an order.

108. The Committee therefore directs that the Registrar issue a Warning to Registrant in the following terms.

On 3 March 2025 General Pharmaceutical Council's Fitness to Practise Committee considered an allegation in relation to Mr Trishul Patel, registration number: 2058183 and determined to issue him with a warning in relation to his misconduct.

Mr Patel was working as a locum Pharmacist during March and April 2022, whereby he undertook a number of sessions as an RP at a pharmacy called Cannabliss (the Pharmacy), which had been established specifically to supply Cannabis Based Medicinal Products (CBMPs).

On a number of occasions during that period, Mr Patel operated the Pharmacy without having adequate governance and safeguards in place. He failed to maintain records to demonstrate that the CBMPs he supplied at the Pharmacy had been appropriately prescribed. While he was locum, he operated the Pharmacy supplying CBMPs despite it not having adequate governance and safeguarding procedures in place. Mr Patel also failed to maintain a proper Responsible Pharmacist log on the dates on which he worked.

Mr Patel's conduct was a breach of the Standards for Pharmacy Professionals as follows:

a. Standard 2 ***Must work in partnership with others:***

Mr Patel did not take action to safeguard people who may be vulnerable, nor did he make adequate records.

b. Standard 5 ***Must use their professional judgement****:*

Mr Patel showed poor judgement by involving himself in this specialist Pharmacy and by failing to ensure that safeguards were in place to manage risks.

c. Standard 9 ***Must demonstrate leadership****:*

Mr Patel was in a position of clinical and regulatory leadership within the Pharmacy but failed to work together effectively or to set safe and compliant parameters within which others should work.

Mr Patel's conduct is entirely inappropriate, amounts to a serious failure to meet standards for pharmacy professionals and is likely to undermine confidence in the profession. It is important for all Pharmacists to proactively apply professional judgement to ensure adequate governance and proper safeguarding systems and processes are in place in their workplace. It is particularly important in relation to CBMPs given the nature of these drugs and the risks they may pose to patients and the public.

Maintaining proper records and ensuring that a patient's prescription history is checked prior to supplying CBMPs is necessary for public safety, upholding proper pharmacy standards, and maintaining public confidence in the profession.

Mr Patel is warned that such behaviour is unacceptable and must not be repeated. This warning will be published on the Register and will be available for 12 months.

Decision on Interim Measure

109. Interim measures are provided for under Article 60 of the Order. Interim measures may only be imposed after an order for removal, suspension or conditions of registration.

110. The Committee's substantive decision will not take effect until 28 days after notice of this decision has been sent, or until any appeal has been finally disposed of.

111. The Committee received submissions regarding interim measures on behalf of the Council. Mr Thomas submitted that an interim measure of suspension was necessary on both public protection and public interest grounds. He relied upon the determination of the Committee at the impairment stage that Registrant 1 presented a future risk. He submitted that there was no certainty about his plans to work, and because the Committee had not heard from Registrant 1, there was no clear risk management plan identified, should Registrant 1 return to work.

112. The Committee accepted the legal advice received which made reference to the GMC cases of Ashton v GMC [2013] EWHC 943 and Gupta v GMC [2001] EWHC Admin 612.

113. The Committee took account of the Council's revised Guidance of March 2024. The Committee considered that Registrant 1 had been equivocal in his correspondence with the Council about his intention to remain or not remain on the Register. The Registrant can during the 28-day period after notice of this decision has been sent and during any appeal period (should he choose to appeal), continue to work unrestricted as a pharmacist. The Committee found that he represents a risk to the public. The Committee determined that an interim measure of suspension properly upholds the standards of the profession and is in the wider public interest.

114. The Committee determined that an interim measure of suspension should be imposed on the following grounds:

1. It is necessary to protect the public, and
2. Is otherwise in the public interest.

115. This concludes the determination.