

General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote online hearing

Monday 11- 14 August 2025

Registrant name:	Mukhwaheguru Singh Sidhu
Registration number:	2203887
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Manuela Grayson (Chair) Jignesh Patel (Registrant Member) Stephanie Hayle (Lay Member)
Legal Adviser:	Ashraf Khan
Committee Secretary:	Chelsea Smith
Registrant:	Present, unrepresented
General Pharmaceutical Council:	Represented by Taz Aldeek, Case Presenter
Facts proved by admission:	1, 2, 3, 6, 7, 8
Facts proved:	4, 5
Fitness to practise:	Impaired
Outcome:	3 month Suspension

This decision including any finding of facts, impairment and sanction is an appealable decision under *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010*. Therefore, this decision will not take effect until 12 September 2025 or, if an appeal is lodged, once that appeal has been concluded.

Particulars of Allegation

“You, a Registered Pharmacist, while acting as the Responsible Pharmacist for Newline Pharmacy Limited, trading as Coast Road Pharmacy, in Tyne and Wear (“Coast Road Pharmacy”):

- 1. Between approximately June 2018 and 18 October 2022, failed to maintain any, or any adequate, records of the quantity of the controlled drugs received into, and/or supplied by, Coast Road Pharmacy, in one or more of the controlled drugs registers. [ACCEPTED and FOUND PROVED]*
- 2. On or about 18 October 2022, failed to ensure that one or more of the controlled drugs registers for Coast Road Pharmacy was on the premises. [ACCEPTED and FOUND PROVED]*
- 3. On or about 18 October 2022, failed to ensure that controlled drugs were stored securely, in that one or more controlled drugs were in unlocked tote bags within the dispensary. [ACCEPTED and FOUND PROVED]*
- 4. Between 19 April 2022 and 5 August 2022, on one or more occasions placed medication returned by patients back into Coast Road Pharmacy stock for reuse. [DENIED and FOUND PROVED]*
- 5. Between 19 April 2022 and 5 August 2022, on one or more occasions instructed Colleague A to use the contents of unmarked dosette boxes to prepare new dosette boxes. [DENIED and FOUND PROVED]*
- 6. On around 18 May 2023, did not ensure that the service for supplying patients with multicompartiment compliance packs was safe, in that the packs were stored unsealed while awaiting accuracy checks. [ACCEPTED and FOUND PROVED]*
- 7. On around 18 May 2023, did not monitor and record fridge temperatures for all fridges used and so could not provide assurance that temperature-controlled medicines are always stored appropriately. [ACCEPTED and FOUND PROVED]*
- 8. On around 18 May 2023, did not ensure that measuring equipment used in the dispensary was clean and hygienic. [ACCEPTED and FOUND PROVED]*

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

Documentation

Document 1 – Council’s bundle of documents (67 pages)

Document 2- Council’s Statement of Case and Skeleton Argument, 6 August 2025 (18 pages)

Document 3- Employer’s Reference dated 18 March 2025 (1 page)

Document 4- CPD documentation (9 pages)

Document 5- Registrant’s reflective document (2 pages)

Witnesses

The Council provided witness statements together with exhibits from the following people:

- a) Controlled Drugs Liaison Officer, Mr D
- b) GPhC Inspector, Ms C
- c) Dispenser and Pharmacy Manager, Witness 1

The Registrant accepted the evidence of Mr D and Ms C.

Witness 1 attended and gave evidence. The Registrant gave evidence at the facts 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 had regard to the guidance contained in the Council's *Good decision making: Fitness to practise hearings and outcomes guidance* as revised March 2024.
5. A Principal Hearing has up to three stages:

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

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

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

Service of Notice of Hearing

6. The Committee has seen a letter dated 7 July 2025 from the Council headed 'Notice of Hearing' addressed to the Registrant. The Committee concluded that good service had been affected in accordance with the Rules.

Registrant's response to Particulars of Allegation

7. The Registrant admitted the facts alleged at particulars 1,2,3,6,7 and 8 of the Particulars of Allegation.
8. In the light of the above, and by the application of Rule 31(6) of the Rules, the Chair announced that those particulars were found proved by the Committee.
9. The Committee then proceeded to receive evidence and submissions regarding particulars 4 and 5 of the Particulars of Allegation.

Background

The Council's referral

10. This case relates to registered pharmacist, Mukhwaheguru Singh Sidhu (Registration number: 2203887). Mr Sidhu was the regular Responsible Pharmacist ("RP") and manager of Newline Pharmacy Limited, trading as Coast Road Pharmacy, in Tyne and Wear (1037719) ("the Pharmacy").
11. Mr D, Controlled Drug Liaison Officer ("CDLO"), undertook an unannounced visit to the Pharmacy on 18 October 2022. At the time it was noted that the Controlled Drugs ("CD") registers were not on the premises. They were later retrieved by Mr Sidhu from his home address.
12. An inspection of the CD registers revealed the registers had not been updated since approximately June 2018.
13. Mr D also discovered a number of tote boxes stacked within the dispensary. Mr D advised Mr Sidhu that all CDs were required to be locked away. Mr D also found the CD cabinet was full, with more stock than he would have expected to see, including out of date CDs that required destruction.
14. Mr D explained that Pharmacy had later reported thirty-five balance errors. On 18 May 2023, Mr D conducted a joint inspection with Ms C, GPhC inspector. During a routine &

intelligence inspection it was identified that the Pharmacy did not ensure that the service for supplying patients with multi-compartment compliance packs was safe, in that the packs were stored unsealed while awaiting accuracy checks. It was further reported by the Inspector that the Pharmacy did not monitor and record fridge temperatures for all fridges used and so could not provide assurance that temperature-controlled medicines are always stored appropriately and did not ensure measuring equipment used in the dispensary was clean and hygienic.

15. Mr D conducted a follow up visit to the Pharmacy on 30 October 2023 and found no cause for concern with regard to the management of Controlled Drugs.
16. Ms M has also provided a witness statement, dated 10 January 2024, to the GPhC. She was a dispenser, and former employee of Newline Pharmacy Limited from 18 April – 5 August 2022. Ms M stated that she witnessed the Registrant removing labels from medication returned by customers and placing them back on the shelves during the period she worked at Pharmacy. She also states that the contents of unused dosette trays were used to populate newer ones.

The Registrant's Response

17. The Registrant responded to the Particulars of Allegation by email dated 27 March 2024, in which he set out the following:
 - a) He apologised for failing to adequately manage Controlled Drugs during the relevant period;
 - b) He stated that all CDs were handed out to patients and received from suppliers correctly;
 - c) He stated that, once he fell behind on logging entries in the CD register in 2018, it was difficult to catch up as intended;
 - d) He stated that he has since entered all CD prescriptions and CD supplies received onto the register immediately, or on the same day, and carried out weekly CD balance checks;

- e) He stated that he has since maintained neat and orderly CD stocks, and has date checked CDs and destroyed patient returned CDs on the same day or the following day;
- f) He reflected that he should have approached the Superintendent Pharmacist for help as soon as he fell behind with the CD registers;
- g) He emphasised that he understood the importance and gravity of controlled drugs management.

18. The Registrant provided a further response dated 17 April 2024 in which he set out the following:

- a) He denied ever having reused or saying that he would reuse patient returned medication or that the contents of old dosette boxes were repurposed in the preparation of newer ones;
- b) He stated that returned medication was disposed of and/or destroyed by a waste disposal company, and that the main reason for looking through medication upon arrival was to ascertain whether there were any returned CDs (which would require marking up with the date returned and storing in the CD cupboard) or sharps;
- c) He refuted several points in Ms M's statement including:
 - i. Muk asked me to leave the medication on the bench so that they could sort through what they could reuse;
 - ii. I remember seeing Muk looking through the bag, taking out a couple of full boxes, pulling the old patient specific prescription labels off and then putting the boxes back on the shelf;
 - iii. Muk rummaged in the boxes and produced an old tray;
 - iv. I remember being told words to the effect that we 'needed to get rid of it all' and that 'it would save us money'.

Oral Evidence

19. Ms M and the Registrant both gave oral evidence on affirmation.
20. Ms M confirmed the contents of her witness statement and answered questions from the Registrant and from the Committee. In particular, she said:
 - She confirmed that she did see the Registrant and other staff putting returned medications back into stock, on average maybe 2-3 times per week;
 - She told the Committee that when she started work at the Pharmacy there were made-up dosette trays stacked up in the green storage boxes in the dispensary with no documentation or paperwork to identify them – she did not know their origin and could not confirm how long they had been there but she thought it was likely to be a long time;
 - She confirmed that on one particular day they had a shortage of one particular medicine and the Registrant gave her a previously made tray out of a storage box and he said she could use the medication to make up the trays she was making. She said all other members of staff did this too - this was not daily but was on a regular basis. She also confirmed that the Registrant asked her to put spare medication from the dosette trays into pots ready for re-use;
 - She said that sometimes when she asked for a particular medication which she needed for a patient, the Registrant would rummage through the storage boxes and find the medication and pass it across.
21. The Registrant read out a statement he had prepared as his evidence-in-chief in which he provided context for particulars 1,2,3,6,7 and 8 which he had formally accepted, and forcefully denied the particulars alleged at 4 and 5. In relation to the latter two particulars he stated that he thought Ms M was nice and he got on well with her and he could not understand why she was making the allegations as they were untrue and did not happen. He said Ms M was lying.
22. In relation to the accepted particulars, the Registrant's evidence in summary was as follows:
 - Particular 1: there were pressures in the Pharmacy, increased workload, inadequately and poorly trained staff whom he had to spend time training, once he fell behind it was

difficult to catch up; however he kept photocopies of all relevant documentation including prescriptions and invoices; he always had the intention of catching up on CD records when he could. In 2019 the backlog increased, there was staff shortage, a new PMR system which he and others needed to learn how to use; then in February 2020 the covid pandemic began which led to lots of staff sickness and increased urgent need from patients. There was then a shop refit creating a lot of change; and until 2022 there was increased demand for flu jabs and covid vaccines; sometimes the queue to be served would be round the street; it was all time-consuming;

- Particular 2: he was working 6-7 days per week sometimes until 2 am. On the instruction of the CD inspector, he began new CD registers; he was then trying to run two registers: backdate the old one and fill in the new one;
- Particular 3: CD returns didn't fit in the CD cupboard so he stored the overflow in totes [boxes] which were then kept away in another cupboard and he used cardboard to separate that from the rest of the dispensary; he himself showed this to the inspector, he was transparent about it, not trying to conceal this;
- Particular 6: he took his first break from work since 2017 in April 2023. During the week he was away from work, errors had been made in the CD register by locums. Prior to that he had been keeping up to date since the inspectors had visited and told him to start new CD records; also the owners had changed some practices and there were new staff;
- Particular 7: there were two fridges for medications, but the RP register only had room to record temperatures for only one fridge which he did – however temperatures were regularly checked for both fridges; after the inspectors' visits he obtained a new book to record details for the second fridge;
- Particular 8: the inspectors found a dirty beaker and tissue in it in a basket but this basket was not being used at the time as it was underneath the basket being used which was clean; the issue was caused by staff negligence as the staff were experiencing increased delegation of responsibility whilst he was working on the CD recording. Following the inspection photos of the cleaned basket etc were sent to the inspector.

- Since October 2022 he has kept up to date with CD record keeping and all the issues raised by the inspectors.

23. In relation to particulars 4 and 5 the Registrant was adamant that they were untrue; he would never compromise patient safety; a shortage of medication would never occur as he could either order medicines for the afternoon or send a delivery driver to collect medication from another nearby branch of the business.

Submissions on Facts

24. Mr Aldeek on behalf of the Council submitted that that the Council accepted that the Registrant was not a bad man, he had tried his best. However, the combination of direct evidence and corroborating evidence supports the facts alleged to the requisite standard, namely the balance of probabilities. He submitted that the Registrant had only admitted those matters which he could not hide but had denied particulars 4 and 5 because they call into question the Registrant's integrity. He said Ms M was credible and would have no motive to lie.
25. The Registrant told the Committee that he had no disciplinary findings against him and had never before been involved in regulatory investigations or with the police; he was a hardworking honest pharmacist with a Masters degree and was passionate about his profession and assisting his community.
26. He said he was very remorseful for the six allegations which he had admitted, he understood the gravity of CD management; he had been working 6-7 days per week from 9 am until 8, 9 or 10 pm since 2017 including at the time of the events. He now works 9-5 with less stress and managed CDs perfectly at work.

Decision on the facts

27. In reaching its decisions on facts, the Committee considered the documentation listed at the start of this determination and all of the oral evidence. The Committee also took account of the submissions made on behalf of the Council and by the Registrant.

28. The Committee accepted the advice of the Legal Adviser.
29. When considering each remaining particular of allegation (particulars 4 and 5), 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.
30. In relation to those particulars found proved on the basis of the Registrant's acceptance, the Committee also took into account exhibits including the notes of the CDs Inspector, Mr D, from the October 2022 inspection, photos of CD registers showing latest entries in 2018, photos of tote boxes with bags of medication, photos of Registers for the destruction of CDs showing latest entries as 2015 and photos of the CD cabinet.

Particular 1

"You, a Registered Pharmacist, while acting as the Responsible Pharmacist for Newline Pharmacy Limited, trading as Coast Road Pharmacy, in Tyne and Wear ("Coast Road Pharmacy"):

1. Between approximately June 2018 and 18 October 2022, failed to maintain any, or any adequate, records of the quantity of the controlled drugs received into, and/or supplied by, Coast Road Pharmacy, in one or more of the controlled drugs registers.

31. As confirmed above, particular 1 was found proved on the basis of the Registrant's acceptance and the evidence contained within the witness statements of the Council's witnesses along with exhibits.

Particular 2:

2. On or about 18 October 2022, failed to ensure that one or more of the controlled drugs registers for Coast Road Pharmacy was on the premises.

32. As confirmed above, particular 2 was found proved on the basis of the Registrant's acceptance and the evidence contained within the witness statements of the Council's witnesses along with exhibits.

Particular 3

3. On or about 18 October 2022, failed to ensure that controlled drugs were stored securely, in that one or more controlled drugs were in unlocked tote bags within the dispensary

33. As confirmed above, particular 3 was found proved on the basis of the Registrant's acceptance and the evidence contained within the witness statements of the Council's witnesses along with exhibits.

Particular 4

4. Between 19 April 2022 and 5 August 2022, on one or more occasions placed medication returned by patients back into Coast Road Pharmacy stock for reuse.

34. In considering this particular the Committee assessed the credibility of Ms M who was the only witness to the alleged facts. It took into account the principles set out in the case of Dutta v GMC [2020] EWHC Admin 1974, in relation to how to assess the reliability of witness evidence. It was of the view that Ms M's evidence had been consistent since her witness statement of 10 January 2024, and took into account that this was approximately two years after the alleged events; it could conceive of no reason why she would lie.
35. As for the Registrant, his denial, though consistent, provided no alternative understanding for what Ms M had said she observed and was instructed to do by him whilst working in the Pharmacy. The Committee took into account that the Registrant would have had no personal financial benefit from reusing returned medication, however it observed that on his own admission, his observance of processes and procedures had fallen behind – in the case for example of CD disposal and record keeping, years behind. It would seem that management in the small dispensary area was in chaos.

36. The Committee took into account that the Registrant is previously of good character and that therefore it should consider his credibility and his propensity to act as alleged in light of that.
37. Having taken all of the evidence into account and applied the above principles as set out in case law, on balance of probabilities, the Committee preferred the evidence of Ms M.
38. Accordingly, the Committee found particular 4 proved.

Particular 5

5. Between 19 April 2022 and 5 August 2022, on one or more occasions instructed Colleague A to use the contents of unmarked dosette boxes to prepare new dosette boxes.

39. In considering this particular the Committee assessed the credibility of Ms M who was the only witness to the alleged facts. It took into account the principles set out in the case of Dutta v GMC [2020] EWHC Admin 1974, in relation to how to assess the reliability of witness evidence. It was of the view that Ms M's evidence had been consistent since her witness statement of 10 January 2024 and took into account that this was approximately two years after the alleged events; it could conceive of no reason why she would lie.
40. As for the Registrant, his denial, though consistent, provided no alternative understanding for what Ms M had said she observed and was instructed to do by him whilst working in the Pharmacy. The Committee took into account that the Registrant would have had no personal financial benefit from using the contents of already filled dosette boxes to prepare new dosette boxes, however it observed that on his own admission, his observance of processes and procedures had fallen behind, and medications were being kept in boxes and bags informally in places in the dispensary on what he intended to be a temporary basis. It would seem that management of medications in the small dispensary area was in chaos.
41. Although the Committee had been provided with no documentary or photographic evidence to corroborate Ms M's witness evidence, it observed that she was an experienced dispenser and pharmacy manager so it considered it unlikely that she would have misunderstood what she was being asked to do.

42. The Committee took into account that the Registrant is previously of good character and that therefore it should consider his credibility and his propensity to act as alleged in light of that.
43. Having taken all of the evidence into account and applied the above principles as set out in case law, on balance of probabilities, the Committee preferred the evidence of Ms M.
44. Accordingly, the Committee found particular 5 proved.

Particular 6

6. On around 18 May 2023, did not ensure that the service for supplying patients with multicompartment compliance packs was safe, in that the packs were stored unsealed while awaiting accuracy checks.

45. As confirmed above, particular 6 was found proved on the basis of the Registrant's acceptance and the evidence contained within the witness statements of the Council's witnesses along with exhibits.

Particular 7

7. On around 18 May 2023, did not monitor and record fridge temperatures for all fridges used and so could not provide assurance that temperature-controlled medicines are always stored appropriately.

46. As confirmed above, particular 7 was found proved on the basis of the Registrant's acceptance and the evidence contained within the witness statements of the Council's witnesses along with exhibits.

Particular 8

8. *On around 18 May 2023, did not ensure that measuring equipment used in the dispensary was clean and hygienic.*

47. As confirmed above, particular 8 was found proved on the basis of the Registrant's acceptance and the evidence contained within the witness statements of the Council's witnesses along with exhibits.

The Impairment Stage

48. Having made its determination in relation to the facts, the Committee went on to consider whether those facts amount to misconduct and, if so, whether the Registrant's fitness to practise is currently impaired by reason of his misconduct.

49. "Misconduct" has been termed a "gateway" which may lead to a finding of current impairment. Article 51(1) of the Pharmacy Order 2010 provides that:

"A person's fitness to practise is to be regarded as "impaired" for the purposes of this Order only by reason of:

(a) misconduct

[various other grounds...]".

50. Article 54(1) of the Pharmacy Order 2010 provides:

"The Fitness to Practise Committee must determine whether or not the fitness to practise of the person in respect of whom the allegation is made (referred to in this article as "the person concerned") is impaired".

51. The Council's Good decision making: Fitness to practise Hearings and Outcomes Guidance (March 2024), ("the Outcomes Guidance") Paragraph 2.12 states:

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

pharmacy technician safely and effectively. In practical terms, this means maintaining appropriate standards of competence, demonstrating good character, and also keeping to the principles of good practice set out in our various standards, guidance and advice.”

Evidence

52. The Registrant’s evidence in relation to stage 2 of the hearing included a professional reference from his employer, a record of continuing professional development, and reflections and examples of remediation set out in his email to the Council of 26 March 2024, and his reflective statement provided to the Committee during the hearing.

Submissions

53. Mr Aldeek, on behalf of the Council, referred the Committee to his skeleton argument and the relevant law. He accepted that the Registrant had no financial incentive for his conduct however he submitted that the conduct which the Committee had found proved was in breach of Regulation 20 of The Misuse of Drugs Regulations 2001, Regulation 3 of The Misuse of Drugs (Safe Custody) Regulations 1973, and Standards 1, 5 and 6 of the Standards for Pharmacy Professionals.
54. As for impairment, Mr Aldeek submitted that the Registrant had shown some but limited insight in that he had denied particulars 4 and 5 throughout these proceedings. He submitted that all the limbs (a) to (d) of Rule 5(2) were engaged on the basis that the Registrant’s misconduct, in the Council’s submissions:
- a) Presented a potential risk to patients or to the public;
 - b) Has brought or might bring the profession of pharmacy into disrepute;
 - c) Has breached several of the fundamental principles of the profession of pharmacy;
 - d) Was such that his integrity could no longer be relied on.

55. Mr Aldeek submitted that given the above the Registrant's fitness to practise is currently impaired both in relation to the protection of the public and in the public interest.
56. The Registrant made detailed submissions. He did not agree that his conduct found proved was serious enough to amount to misconduct and he submitted that his fitness to practise was not currently impaired. In relation to particulars 4 and 5 which he had denied, he said he respected the Committee's decision and appreciated the seriousness of its findings. He said he had never had any bad intent nor had he intentionally done anything which might harm patients. He set out in helpful detail all of the learning and actions he has taken to ensure that the conduct to which he had admitted has not since the relevant time been, and will not in future be, repeated. These included the following:
- He told the Committee that he fulfils all of the requirements of paragraph 2.12 of the Outcomes Guidance set out above;
 - He always champions patient safety, for example in health campaigns over the years including in relation to epilepsy in pregnancy, cardiovascular health, cancer awareness; he has undergone and given training in safeguarding adults; he himself has no physical impairment and he is mentally strong;
 - He always reports near misses and trains staff where such issues have arisen – he gave an example of such an issue which had recently occurred;
 - He understands the definition of serious misconduct. He always follows relevant codes of conduct, never undermines the trust of the public;
 - He explained in relation to each of the Committee's findings to which he had admitted how he has changed his practice to ensure he does not repeat his conduct – for example he has since Mr D's visit in 2022 always followed SOPs about the storage, handling and destruction of CDs; destroys CDs immediately on receipt or on the same day; he keeps accurate CD records and fridge temperature records; he ensures the pharmacy is clean and hygienic; he always seals multicompartment boxes of medicines on the day they are made up; has trained staff on medicine safety including shelf storage and "LASA" (Look Alike, Sound Alike) medications;

- He provided examples of how he gives accurate advice and counselling to patients on the proper use of medications;
- He told the Committee that since October 2024 his place of work is part of the Pharmacy First scheme: he is trained in this and provides additional services including providing weight loss medication and the appropriate monitoring thereof; he takes regular breaks in a calendar year, and continuously reviews regulations and guidance and reads updates on MHRA alerts and other matters in professional publications;
- He has continued to show leadership and has learned to speak up if he has concerns for example by contacting GPs if prescriptions seem inappropriate.

The Committee's Decision

57. The Committee took into account the submissions on behalf of both parties, the relevant law and guidance, including reference to the Council's "Good Decision- making: fitness to practise hearings and outcomes guidance" (March 2024), and the Council's 67-page bundle, and also the further evidence of CPD and reflections , and the professional reference provided by the Registrant during the hearing. It bore in mind that it was a matter for its own professional judgement whether the conduct it had found proved was so serious as to amount to misconduct; and whether if so, the Registrant's fitness to practise is currently impaired.
58. The Committee accepted the helpful advice of the legal adviser who referred to relevant statute, regulations and case law.
59. The Committee accepted the late provision of documentation from the Registrant under Rule 18 of the Rules, bearing in mind that he was unrepresented, that Mr Aldeek had no objection to its doing so, and also that the documents were relevant to Stage 2 of the hearing and not to the facts stage.
60. It took into account the Council's overarching objective which is the protection of the public, by:
 - protecting, promoting and maintaining the health, safety and wellbeing of the public

- promoting and maintaining public confidence in the profession
- promoting and maintaining proper professional standards and conduct for members of the profession.

Misconduct

61. The Committee accepted the submissions of Mr Aldeek in relation to the Registrant's breaches of legislation designed to ensure safe management of controlled drugs. Given its findings of fact in relation to the Particulars of Allegation, the Committee was satisfied that the Registrant breached Regulation 20 of The Misuse of Drugs Regulations 2001, which required the Registrant to make entries in the Controlled Drugs registers on the day on which the drug is obtained and/or supplied, or the next following day. Further, it sets out that the register needed to be kept at the premises to which it relates. He was also in breach of Regulation 3 of The Misuse of Drugs (Safe Custody) Regulations 1973 which required controlled drugs to be "kept in a locked safe, cabinet or room which is so constructed and maintained as to prevent unauthorised access to the drugs".
62. On the 18 October 2022, the day of the inspection, the Registrant notified the Inspector that the records were not at the premises and accepted that records had not been updated since 2018, both of which placed the Registrant in breach of the regulations.
63. Turning to consider the Council's "Standards for pharmacy professionals" (May 2017), the Committee was of the view that the Registrant breached standards 1, 5, 8 and 9.
 - a. **Standard 1: pharmacy professionals must provide person-centred care:** The Committee was of the view that its findings of fact in relation to the Registrant instructing or allowing the re-use of medications which were already in dosette boxes and also of re-using medication returned by customers could have compromised patient safety: he had no way of knowing whether the medications could have degraded due, for example, to inappropriate storage outside of the pharmacy; there were no labels on the medications in dosette boxes to verify an accurate audit trail, for example to identify batch number/ date of expiry. This all amounted to a breach of the expectation in Standard 1 that the Registrant should make the care of the patients his first priority.

- b. Standard 5: pharmacy professionals must use their professional judgement:** The Registrant failed to keep accurate records and properly store returned Controlled Drugs all of which were legal requirements for their safe management. This apparently lasted over a very considerable period of time, 2018-2022. In the Committee's opinion, this would have resulted in possible chaos and confusion in relation to the proper auditing of the medications. Moreover, the Committee was concerned that the Registrant's conduct in relation restocking customer returns and transferring medications from unmarked and unlabelled dosette trays for potential or actual re-use, was also a failure to use his professional judgement. By his actions the Registrant compromised safe and effective care and in doing so, showed a poor exercise of professional judgement.
- c. Standard 8: Pharmacy professionals must speak up when things go wrong:** The Registrant admitted that he had fallen behind in record-keeping and destruction of CDs and he was storing CD registers at home in the hope of catching up. He admitted that at first he lied to the CD inspector in 2022, because he panicked; and he has accepted that he should have spoken up earlier and sought help from the Superintendent. He did not, as required by standard 8, "raise a concern even when it is not easy to do so".
- d. Standard 9: pharmacy professionals must demonstrate leadership:** The Registrant failed to show leadership as the Responsible Pharmacist in instructing Ms M, who was a dispenser, to use the contents of unmarked dosette boxes to prepare new dosette boxes. In addition, his chaotic failures to keep the CD registers up to date and safely store and destroy CDs whilst in the role of responsible pharmacist, placed him in breach of the requirement to lead by example.
64. 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).
65. The Committee next turned to consider whether the facts found proved reached the threshold of seriousness for a finding of professional misconduct. The Committee took into account the relevant case law including the case of Roylance and General Medical Council (No.2) [2000] 1 A.C. 311 which states that:

“Misconduct is 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 the case of Meadow v General Medical Council [2006] EWCA Civ 1390 [2007] 1 QB 462, which states:

“In short, the purpose of fitness to practise proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FPP thus looks forward not back. However, in order to form a view as to the fitness of a person to practice today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past...[The professional’s] misconduct at a particular time may be so egregious that, looking forward, a panel is persuaded that [the professional] is simply not fit to practise...without restrictions, or maybe not at all. On the other hand, [their] misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practise Panel could conclude that, looking forward, his or her fitness to practise is not impaired, despite the misconduct.”

66. The Committee was of the view that the facts found proved at particulars 1 to 5 which included failure to maintain accurate CD registers for a prolonged period from 2018 to 2022, removing CD registers from the pharmacy premises; failure to store CDs safely in accordance with regulations; placing returned medications back into stock; and instructing staff to re-use medications from previously filled dosette boxes, all clearly fell short of what was to be expected of him as a registered pharmacist. All those matters risked causing patient harm and would have been fundamental responsibilities of any pharmacist and particularly a pharmacist in the Registrant’s position of seniority as the RP. The Committee was satisfied that those matters were serious enough to amount to misconduct.
67. As for the facts found proved at particulars 6, 7 and 8, the Committee is of the view that whilst they breached professional standards, they were not so serious on their own as to amount to misconduct. In relation to particular 6, whilst serious if it was a regular procedure, the Committee had no evidence before it as to whether this issue was a regular one or was chanced upon on the day of the inspector’s visit. In relation to particular 7, the

Committee accepted that although fridge temperatures of one of two fridges were not being monitored and recorded, they were however regularly checked; and as for particular 8, it appeared that the only issue raised by the inspectors was in relation to one dirty beaker and a tissue which, the Registrant said, and the Committee accepted, would likely have been cleaned in due course before being used.

68. Accordingly, the Committee concluded that the alleged ground of misconduct, was established by the proven facts at particulars 1 to 5 of this case.

Decision on Impairment

69. Having found that the ground of misconduct was established, the Committee went on to consider whether the Registrant's fitness to practise is currently impaired. Rule 5 of the Rules sets out the criteria which the Committee must consider when deciding, in the case of any Registrant, whether or not the requirements as to fitness to practise are met.

70. Rule 5(2) of the Rules provides:

"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 upon."

71. Guidance on this issue was set out by Mr Justice Silber in Cohen v General Medical Council [2008] EWHC 581 (Admin) at paragraph 65:

“It must be highly relevant in determining if a [practitioner’s] fitness to practise is impaired that first ... his conduct that led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated”.

72. Those principles are echoed (and adapted in different words) in the Council’s Guidance at paragraph 2.15:

“The committee should also 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 ...”*

73. The Committee carefully considered all of the evidence before it in light of the above principles. It took into account that the Registrant has accepted all but two of the particulars which in itself demonstrated a degree of insight into his failings.

74. The Committee was of the view that the Registrant’s conduct which led to the charge was in principle remediable, that is, able to be addressed. As for whether the Registrant had, in fact, addressed his conduct, the Committee carefully considered the evidence he had provided in relation to current impairment.

75. The Committee was told by the Registrant that he is currently working as a locum RP for a different branch of the same employer, having stopped working at the Pharmacy where the events took place in November 2023. He said the environment is less stressful and he is able to work 9-5pm and complete all his CD recording on time and destruction of CDs on the same or the following day.

76. The Committee took into account the reference from his employer Superintendent Mr R, dated 18 March 2025, in which Mr R stated that there have never been any complaints

about the Registrant from customers, staff or NHS England and the Registrant's "conduct as a professional has been nothing less than perfect". The referee added that since the Registrant has moved to another branch, spot checks on CD balances have always been accurate and complete. Mr R continued:

"All entries are done on the day before the allocated 24 hours and returned CD entered into the destruction register without fail in a timely manner". Mr R did not envisage *"a mishap of the earlier conduct"*. Mr R concluded:

"We have full faith as employers and GPhC members that [the Registrant] is a fully committed integral part of the pharmacy profession".

77. The Committee also took into account the contents of the supplemental witness statement of the CD Inspector, Mr D, dated 8 January 2024, in which Mr D stated that on a visit to the Pharmacy on 30 October 2023, Mr D, "did not find any cause for concern with how the Pharmacy was functioning with regard to the management of controlled drugs".
78. The Committee also took into account the evidence of CPD which the Registrant has undertaken since the relevant events; and it observed that it has no information before it to suggest that the Registrant has repeated his misconduct since the time of the relevant events, and that he has been in continuous employment as a pharmacist since that time.
79. The Committee took into account all of the helpful examples which the Registrant had summarised in his submissions listing the efforts he has gone to, improving his practice since the time of the events. It was reassured that he has gained insight into the seriousness of his previous failings. The Committee also noted the content of the Registrant's reflective statement August 2025 (today's date), and in particular the following comments:

"I am going to strive to continue to represent the pharmacy profession in the best light possible, upholding the reputation of the profession. I will continue to provide patient safety and patient centred care to my patients and customers in the pharmacy. I have a real desire to help patients with their medical needs as well as providing excellent individualised and bespoke advice on their medical concerns.

I enjoy my job as a pharmacist very much and it is very fulfilling for me. I respect the

pharmacy profession wholeheartedly and its very high standards of practice. I will always look to keep learning and updating my knowledge and skills whether that be through CPD's, online courses, assessments and face to face events to learn from other members of the pharmacy community being that pharmacists, dispensers and MCA's. Feedback and gaining knowledge on how to improve services and protocols from all that work in the pharmacy setting is crucial and important. I will continue to read up to date guidelines and information as well as MHRA safety alerts".

80. Taking the evidence before it of the Registrant's reflection and remediation into account, and bearing in mind that it had before it evidence not only from the Registrant himself but also from Mr D and from the Registrant's employer that there have been no further examples of the conduct which led to the complaint, the Committee is of the view that the Registrant has now fully addressed his previous conduct. It is not likely to be repeated.
81. Turning to Rule 5(2), it follows that Rule 5(2) (a) is not currently engaged, in that the Registrant does not present an actual or potential risk to patients or the public. As for Rule 5(2)(b), the Committee does not consider that the Registrant might bring the profession of pharmacy into disrepute (although he may have done so if judged at the time of the conduct).
82. As for Rule 5(2)(c) - whether he breached one of the fundamental principles of the profession, the Committee's view was that whilst he did at the time breach his professional standards as set out above, there is no continuing breach as at today's date, of the fundamental principles of his profession.
83. Finally, in relation to Rule 5(2)(d), the Committee does not consider that the Registrant's integrity can no longer be relied upon. It observed that although it had found particulars 4 and 5 proved, Mr Aldeek on behalf of the Council had acknowledged that the Registrant's conduct had not been in pursuit of any personal financial incentive; and whilst the Committee must not speculate as to the reasons for his conduct, the facts found proved and the Registrant's explanations of the context at the time, suggest that processes at the Pharmacy and the Registrant's ability to properly manage them, were in a state of some considerable chaos and confusion at the time. It would appear that the Registrant's conduct

at particulars 4 and 5, though serious, formed part of that chaos and were not indicative of a fundamental lack of integrity.

84. The Committee does not therefore consider that the Registrant's fitness to practise is currently impaired on the personal component, that is for the protection of the public.
85. The Committee next went on to consider the wider public interest. The Committee bore in mind the well-known case of CHRE v NMC and Grant [EWHC] 927 (Admin), in which Mrs Justice Cox stated that a panel must consider whether *"the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances"* of a case.
86. Taking all of the evidence before it into account, the Committee is satisfied that members of the public, if they were fully apprised of the facts of this case, would be surprised if a finding of impairment were not made in the wider public interest, in order to send a message to the public and the profession, as to the standards of practice which the regulator expects to be observed by registered pharmacists.
87. For all the reasons set out above, the Committee finds the Registrant's fitness to practise is currently impaired in the wider public interest, that is, in order to uphold proper professional standards and maintain public confidence in the professions regulated by the Council.

Decision on Outcome

88. Having determined that the Registrant's fitness to practise is impaired on public interest grounds, the Committee went on to consider the appropriate and fair outcome.
89. The Committee's powers in relation to outcome are set out in Article 54(2) of the Pharmacy Order 2010.
90. Article 54(2) of the Order provides:

"If the Fitness to Practise Committee determines that the fitness to practise of the person concerned is impaired, it may–

- a. *give a warning to the person concerned in connection with any matter arising out of*

or related to the allegation and give a direction that details of the warning must be recorded in the Register,

- b. give advice to any other person or other body involved in the investigation of the allegation on any issue arising out of or related to the allegation;*
- c. give a direction that the entry in the Register of the person concerned be removed;*
- d. give a direction that the entry in the Register of the person concerned be suspended, for such period not exceeding 12 months as may be specified in the directions; or*
- e. give a direction that the entry in the Register of the person concerned be conditional upon that person complying, during such period not exceeding 3 years as may be specified in the direction, with such requirements specified in the direction as the Committee thinks fit to impose for the protection of the public or otherwise in the public interest or in the interests of the person concerned.”*

The Committee may also make no order.

91. The Committee was aware that it should consider the available outcomes in ascending order from the least restrictive, taking no action, to the most restrictive, removal from the Register, in order to identify the appropriate and proportionate outcome that meets the circumstances of this case. It bore in mind that the purpose of the outcome is not to be punitive, though an outcome may in fact have a punitive effect. The purpose of the outcome is to meet the overarching objectives of regulation, namely the protection of the public, the maintenance of public confidence, and to promote and uphold professional standards. The Committee is therefore entitled to give greater weight to the public interest over the Registrant’s interests.
92. The Committee had regard to the GPhC’s guidance, entitled: Good decision making: Fitness to practise hearings and outcomes guidance (March 2024), (“the Good decision making Guidance”) which reminds the Committee that it must consider the full range of outcomes.

Submissions

93. Mr Aldeek submitted that the appropriate and proportionate order was one of suspension for a period of two months. He informed the Committee that whilst it was correct that the Registrant had no previous regulatory findings against him, there had been a concern raised in connection with a trainee pharmacist administering covid booster vaccinations in an unsanitised area in the Pharmacy, in March 2022, when although this was the trainee's responsibility, the Registrant was in a managerial role as RP. No further action was taken by the Council on that occasion. He set out some aggravating features of the findings and also suggested some mitigating features which the Committee should take into account. He accepted on behalf of the Council that the findings in this case were as a result of strenuous conditions created in part by Covid and that the Registrant was under considerable stress at the time. Also, he accepted that the findings at particular 4 and 5 did not concern a lack of integrity but formed part of the chaos and mismanagement at the time.
94. The Registrant submitted that he had demonstrated through numerous examples of his good practice since the relevant events that he is no danger to the public, but rather has fully remediated his failings through CPD and extensive reflection and insight. He listed all the services which he has been providing, including the recent addition of Pharmacy First prescribing, consulting with patients both by phone and face to face (at least 10 per day), including babies, vulnerable adults, elderly patients, their carers or health care providers, and methadone users. He told the Committee that the branch of the pharmacy business he has been working at regularly since late 2023 handles approximately 16,000 items per month and that patients regularly tell him that they come to him for services because they trust his advice and have confidence in him.
95. He submitted that he fully understands the importance of observing pharmacy standards and of this regulatory process, and he submitted that a fair outcome would be for the Committee to take no action.

The Committee's Decision

96. The Committee had regard to the relevant law and to the Council's 'Good decision making: Fitness to practise hearings and outcomes guidance' (March 2024)' ("the Good decision making Guidance"), to inform its decision. It took into account the submissions made by Mr Aldeek, and by the Registrant, and accepted the legal advice of the legal adviser.
97. The Committee first considered what, if any, aggravating and mitigating factors there may be.
98. The Committee identified the following aggravating factors:
- The Registrant not only breached several Pharmacy professional standards but also breached legislation in relation to the management of Controlled Drugs;
 - The conduct in relation to Controlled Drugs was sustained over a prolonged period of time;
 - The Registrant delayed allowing the CD inspector to visit and lied about the whereabouts of the CD registers and for how long he had fallen behind in completing them when first asked by the inspector;
 - In relation to the Registrant repurposing or reusing medication, there could have been a risk of harm to end-users;
 - As Responsible Pharmacist, the Registrant was in a senior role at the Pharmacy.
99. The Committee identified the following mitigating factors:
- The Registrant had worked for some time prior to these events without issues being raised as to his practice;
 - Positive character reference from his employer.

100. The Committee next turned to consider the outcomes available to it in ascending order.
101. Take No Action: The Committee first considered whether it would be appropriate to take no action, however it was of the view that this outcome would not be sufficient to send a message to the public and the profession reflecting the seriousness of the Registrant's misconduct.
102. Warning: The Committee next considered whether issuing a warning would be appropriate but it decided that a warning would not be appropriate for the same reasons as above, namely that a warning would not sufficiently mark the public interest.
103. Conditions of Practice. The Committee next considered whether to impose conditions of practice. The Good decision making Guidance states that conditions may be appropriate where there is evidence of poor performance, or significant shortcomings in a professional's practice, but the Committee is satisfied that the professional may respond positively to retraining and supervision; and where there is not a significant risk posed to the public by the imposition of conditions.
104. The Committee observed that the Registrant had been in practice, including working in the role of RP, since the time the events were referred to the Council, without further concerns being raised about his professional standards. He has told the Committee that he now observes the required procedures for safe management of Controlled Drugs and this has been confirmed by way of independent evidence from his employer and from the CD inspector. The Committee has determined that the misconduct is not likely to be repeated. In these circumstances it would not be appropriate and would be disproportionate to impose an order for conditional entry on the Register restricting the Registrant's practice.
105. Suspension Order. The Committee next considered whether suspension would be a proportionate outcome.

106. It took into account that Mr Aldeek had submitted that suspension would be proportionate, whilst the Registrant had submitted that it would be disproportionate.

107. The Committee carefully considered the Council's Good decision making Guidance which indicates that suspension may be appropriate where:

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

108. The Committee took into account that the Council's Good decision making Guidance states at paragraph 5.7 and 5.8 that in reaching a decision on what outcome to impose, the Committee should give appropriate weight to the wider public interest. The Committee is entitled to give greater weight to the public interest, than to the consequences for the professional. Even if an outcome will have a punitive effect, it may still be appropriate.

109. The Committee therefore turned to consider whether a suspension would be adequate and proportionate to maintain public confidence in the profession and proper standards of behaviour.

110. The Committee bore in mind that the Registrant has been working as a pharmacist for several years since the events came to light with no further concerns raised against him. The Committee also properly weighed its earlier conclusion that the misconduct it had found proved in this case has been addressed in relation to the personal component, that is, the protection of the public.

111. After careful consideration, the Committee concluded that a period of suspension would satisfactorily mark the seriousness and nature of its findings. It was satisfied that members of the public, were they to be appraised of all the evidence in this case, would consider it appropriate, reasonable and fair that this Registrant should be suspended from working as a pharmacist for a short period of time so as to send

an important message to the profession, to patients and to the public, about the seriousness of this Committee's findings. This will make clear the fundamental responsibility for pharmacists to take seriously their role and privilege as gate-keepers of medicines, including Controlled Drugs. It will serve as a deterrent to the Registrant's fellow professionals, ensuring that they observe all the necessary procedures for safe management of all medicines.

112. The Committee considers that a period of three months' suspension is appropriate and proportionate to the seriousness of this case. This period of suspension will properly reflect the public interest considerations, which include:
- protecting the public;
 - maintaining public confidence in the profession; and
 - maintaining proper standards of behaviour.
113. The Committee does not consider that the suspension needs to be reviewed before its termination as it has been imposed in the public interest alone. The suspension will therefore expire at the end of the period of suspension and then the Registrant will be permitted to return to the register unrestricted.
114. Removal. Having concluded that a period of suspension would satisfactorily mark the public interest which it has identified, the Committee considered whether removal was in fact more appropriate. It concluded that removal, which is reserved for the most serious conduct, would be unduly punitive.
115. The Committee therefore directs that the entry in the Register of Mr Mukhwaheguru Singh Sidhu, whose registration number is 2203887, be suspended from the register for a period of three months.
116. That concludes this determination.