

General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote videolink hearing

Wednesday 27- Thursday 28 August 2025

Registrant name:	Kofi Akuamoah Boahene
Registration number:	2052979
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Neville Sorab (Chair) Jignesh Patel (Registrant member) Paul Barton (Lay member)
Committee Secretary:	Adam Hern
Registrant:	Present and represented by Tim Haines
General Pharmaceutical Council:	Represented by Zain Choudry, Case Presenter
Facts proved:	None
Facts proved by admission:	All
Facts not proved:	None
Fitness to practise:	Impaired
Outcome:	Suspension – 4 months
Interim measures:	Interim Suspension

This decision including any finding of facts, impairment and sanction is an appealable decision under *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010*. Therefore, this decision will not take effect until 26 September 2025 or, if an appeal is lodged, once that appeal has been concluded. However, the interim suspension set out in the decision takes effect immediately and will lapse when the decision takes effect or once any appeal is concluded.

Particulars of Allegation (as amended)

You, a Registered Pharmacist, whilst working as a locum at Wells Pharmacy 638-640 Wolseley Road, Plymouth, PL5 1TE

1. *On 03 August 2021 in relation to Patient A, a child:*
 - 1.1. *Failed to check the patient's name and/or date of birth before administering a vaccination; **ADMITTED***
 - 1.2. *Failed to explain the risks of the vaccination to the patient's mother; **ADMITTED***
 - 1.3. *Failed to obtain informed consent from the patient's mother for the administration of Zostavax to Patient A; **ADMITTED***
 - 1.4. *Administered a Zostavax vaccination, which was not prescribed or covered under a Patient Group Direction; **ADMITTED***
 - 1.5. *Inserted the same needle into their skin on two or more occasions; **ADMITTED***
 - 1.6. *Failed to make an adequate record of their appointment. **ADMITTED***
2. *Failed to check and/or review the Patient Group Direction on Varivax (chickenpox) vaccine before the patient's appointment. **ADMITTED***
3. *Your actions at 1.4 above were outside of your scope of competence in that:*
 - 3.1. *You were not a Pharmacist Independent Prescriber; **ADMITTED***
 - 3.2. *You had not been trained to administer the vaccine. **ADMITTED***

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

Documentation

Document 1- Council hearing bundle

Document 2- Council skeleton

Document 3- Registrant hearing bundle

Document 4- Registrant skeleton

Determination

Introduction

1. This is the written determination of the Fitness to Practise Committee at the General Pharmaceutical Council (“the Council”).
2. The hearing is governed by *The Pharmacy Order 2010* (“the Order”) and *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010* (“the Rules”).
3. The statutory overarching objectives for these regulatory proceedings are:
 - a. To protect, promote and maintain the health, safety and well-being of the public;
 - b. To promote and maintain public confidence in the professions regulated by the Council; and
 - c. To promote and maintain proper professional standards and conduct for members of those professions.
4. The Committee also has regard to the guidance contained in the Council’s *Good decision making: Fitness to practise hearings and outcomes guidance* as revised March 2024.
5. A Principal Hearing has up to three stages:
 - Stage 1. Findings of Fact – the Committee determines any disputed facts.
 - Stage 2. Findings of ground(s) of impairment and impairment – the Committee determines whether, on the facts as proved, a statutory ground for impairment is established and, if so, whether the Registrant’s fitness to practise is currently impaired.
 - Stage 3. 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 16 June 2025 from the Council headed “*Notice of Hearing*” sent by email to the Registrant. The Notice of Hearing was sent more than 28-days prior to the commencement of the hearing, stated the date, time and venue of the hearing, and also contained the finalised particulars of the allegation. The Committee was satisfied that there had been good service of the Notice in accordance with Rules 3 and 16.

Preliminary matters – conflict of interest

7. It was raised on the record that the Lay Committee Member, Mr Barton, worked in the same organisation as Mr Daren Standen, a Council Case Officer who has provided a statement in this case. It was placed on the record that although Mr Barton and Mr Standen worked in the same organisation, they are not friends socially, have not worked directly with each other, or have line managed each other.
8. Both parties set out that they did not consider this to be a conflict of interest and that they had no objection to Mr Barton being on the Committee for the purposes of this Principal Hearing. The Committee did not consider there to be a conflict of interest for Mr Barton to be a member of the Committee.

Background

9. At the relevant time the Registrant was employed by Well Pharmacy, Stoke, Plymouth PL3 4DH (“the Pharmacy”) as a locum pharmacist. It is not in dispute that the Registrant was not an independent prescriber at the time of the allegations.
10. It is Ms Person A evidence that on 2 August 2021, her child, Patient A, was booked in for a private vaccination for chickenpox at the Pharmacy. Ms Person A booked the appointment online on 29 July 2021. The online booking included completion of a questionnaire for the administration of the vaccine. After the online booking was made, Ms Person A received a call from the pharmacy to say the vaccine needed to be ordered and was assured that both dosages would be ordered for the scheduled appointment.
11. Prior to attending, Ms Person A called the Pharmacy to enquire about the site of injection, so she could apply numbing cream to reduce the pain of the injection as Patient A was only 2 years old at the time. Ms Person A spoke to an employee at the Pharmacy. Ms Person A overheard a response: *“oh I haven’t given that vaccine before, is it given in the buttock?”* The employee on the phone said she felt it was given in the arm and she asked Ms Person A to call back once they had clarified. The employee later confirmed the injection would be administered in the arm.
12. On attending the Pharmacy on 2 August 2021, Ms Person A was told there was an issue with the “plunger” and that the appointment would have to be rearranged. The following day the Pharmacy called Ms Person A to say the vaccine was ready and they arranged for them to attend that afternoon.
13. Ms Person A states that the appointment was with the Registrant and that the vaccine was already drawn when they entered the room. Aside from an apology for not having given the vaccine the day before, there was no additional discussion with the Registrant, or questions regarding Patient A’s identity including their date of birth, details of the vaccine, risks of the vaccine or confirmation of consent.

14. Ms Person A states that the Registrant stuck the same needle into Patient A's arm a few times causing Patient A to cry out in pain. She states the Registrant attempted to inject the upper left arm using the same injection twice and that the needle went in but not deep enough to administer the vaccine. Ms Person A states Patient A was very distressed by this point and this appeared to fluster the Registrant, where he once again pulled the needle out and went back in again with the same needle to complete the administration of the vaccine. Ms Person A states she was trying to distract Patient A during this but was keeping an eye on the administration process to notice the attempts made by the Registrant. She states she heard the Registrant say *"oh it wont go in"*.
15. After the administration of the vaccine, Ms Person A requested its details in order to update her GP, and was provided with a post it note. It was only at this point the Registrant asked for Patient A's name and date of birth. Ms Person A asked the Registrant when the second vaccine would be due and she states he did not seem to know the answer. Ms Person A brought up the NHS guidance on her phone for Varivax vaccine which stated a 4-8 week gap is required before the second vaccination following which Ms Person A booked this appointment for 5 weeks from the date of vaccination.
16. After leaving the Pharmacy, Ms Person A called the Pharmacy to raise concerns about the way the vaccine had been administered. She also looked up the vaccine that was named on the post it note and realised that it was not the chicken pox vaccine Varivax, which was what they had booked in for. She became aware that Patient A was given Zostavax MSD 0.65MG and that this was a vaccine given to adults to treat shingles.
17. Ms Person A states upon realising this, she called the Pharmacy back to explain what had happened. Ms Person A states *the "dispensing lady"* checked the bin for the vaccine and it was then checked against BNF and confirmed that Zostavax MSD 0.65mg was the vaccine that been given to Patient A.
18. In the 2 hours from administration of the vaccine Patient A had *"developed strange red and purple spots on [their] forehead, scalp and behind [their]right ear"* and Patient A was taken to A&E on advice from NHS 111.
19. Patient A spent approximately nine hours in A&E under observation, but their rash did not appear to get worse and Patient A was discharged home with agreement for Ms Person A to report the incident to Public Health England which Ms Person A did. Patient A had no lasting injury but Ms Person A mentions in her statement Patient A *"is afraid of the Dr's, hospitals and dentists, [they do] not trust these environments and has a really hard time every time we take [them] to any of these places"*.
20. Well Pharmacy's Patient Group Direction ("PGD") relating to Varivax, valid from 01 April 2020 to 31 March 2023, states that *"The PGD will only apply to community pharmacists who have satisfactorily completed the training which supports this PGD scheme"* and users are to *"ensure the authorisation for the PGD is signed and dated [...] before commencing [...] Varivax vaccination programme"*. The PGD further advises

that to supply or administer POM medicines without authorisation is contrary to the Medicines Act 1968 and Human Medicines Regulations 2012 and may result in prosecution.

21. The BNF (in place March – September 2021) records Varilix and Varivax as vaccines against chickenpox for administration to children and adults. Zostavax is recorded as a vaccine against shingles for administration to adults between 70 and 79 years.
22. The Registrant states that:
 - a. he ordered Zostavax because Varivax was out of stock and on checking BNF he believed Zostavax was an alternative.
 - b. he was unaware of PGD and said he did not read or sign it.
 - c. it *“does not say Zostavax is restricted to adult vaccinations only”*.
 - d. Patient A’s appointment ought not to have been made because the Pharmacy did not have a branch manager at the time, and it is only the branch manager that is fully trained to give the chicken pox vaccination.
 - e. even though Zostavax is not listed in the PGD it is effective against chicken pox.
 - f. he told the staff at the Pharmacy that he had not had specific training to administer chicken pox vaccines; only training to administer flu vaccines. However, the staff insisted that the Registrant administers the chicken pox vaccine. Although the Registrant sets out that he should have asked for help from an area manager or from the superintendent pharmacist, he did not.
 - g. As he had never administered a vaccine to a child before, he could not insert the syringe into her shoulder and due to her thin skin, the vaccine was not administered, instead dribbling down her arm.

Evidence

23. The Committee received, amongst other evidence, the following:
 - a. a witness statement from Ms Person A, the contents of which formed part of the background, set out above.
 - b. Photos of:
 - i. The injection site (following the injection) on Patient A’s left arm.
 - ii. The site of the rash on Patient A’s forehead.
 - iii. The rash on Patient A’s neck.
 - iv. The post it note provided by the Registrant.
 - c. The PGD.

- d. Email and reflective statement from the Registrant.
- e. Further submissions from the Registrant to the Investigating Committee.
- f. Character references for the Registrant.
- g. A statement from the Registrant, dated 18 August 2025, which sets out:
 - i. He fully admits the allegations against him.
 - ii. He was unaware prior to minutes before the appointment on 2 August 2021 that arrangements had been made for Patient A to receive a private chicken pox vaccination.
 - iii. He told his colleagues that he was not trained to undertake the vaccine and that he had never done one before (although he had conducted hundreds if not thousands of flu vaccinations since around 2011). He also made clear he had never vaccinated a child before.
 - iv. However, his colleagues persuaded him to undertake the vaccination as it was a service which the Pharmacy offered. He now recognises that he should have been far stronger than he was at the time and that he should have refused to undertake the vaccination.
 - v. He was unable to suitably make up the vaccine on 2 August 2021 and there was also a problem with the needle plunger. This meant that the booking had to be cancelled.
 - vi. After Patient A and her mother left the Pharmacy steps were taken to re-order another Varivax vaccine. However, this was out of stock from the Suppliers which the branch usually used. The Registrant therefore reviewed the BNF to identify an alternative vaccine. He ordered Zostavax believing this to be a direct replacement for Varivax. It did not register with the Registrant that Zostavax is a medication primarily aimed at vaccinating against shingles in the elderly.
 - vii. The Registrant accepts that he did not read the Well PGD for chicken pox which would have told him that the Zostavax was not listed there in any event.
 - viii. The Zostavax vaccine was delivered to the Pharmacy the following day and arrangements were made with Patient A's mother for her to bring her child into the Pharmacy later that day. The Registrant had repeated to his colleagues his concerns that he was not trained to administer a chicken pox vaccination nor had he vaccinated a child before but again he was encouraged to do it and that all would be fine.
 - ix. The Registrant now recognises that it was completely wrong to have acted outside of his competence and to have undertaken the vaccination and that

he should have refused. He did not “take control” as he should have as the Responsible Pharmacist.

- x. He does not dispute what Patient A’s mother says about what happened prior to, during and after the appointment when he administered the vaccine to her child.
 - xi. He did not verify Patient A’s details with Ms Person A prior to administering the vaccine but he was satisfied that they were the same two people who had attended the pharmacy the previous day so he had satisfied himself in his head that Patient A was the child booked to receive the vaccine. He accepts that he should have verified the relevant details before proceeding to undertake the vaccine.
 - xii. He accepts that he did not explain the risks of the vaccination to Patient A’s mother.
 - xiii. He did not advise Patient A’s mother that Zostavax had been re-ordered in place of Varivax. It therefore follows that he did not obtain Patient A’s mother’s informed consent to use the replacement vaccine.
 - xiv. He accepts that he struggled to administer the vaccine and that he inserted the needle into Patient A’s skin on two or more occasions.
 - xv. He did not make a record of the appointment.
 - xvi. He accepts that he acted outside of his competency in administering the vaccine on 3 August 2021. He was not then and never has been a Pharmacist Independent Prescriber. Nor had he been trained at that time to administer a chickenpox vaccine. Although he successfully completed this training in 2024, he has never conducted a chickenpox vaccination. He has also not vaccinated or attempted to vaccinate any other child since 3 August 2021.
 - xvii. Since August 2021, he has continued to administer many adult flu vaccinations without any concerns being raised.
 - xviii. He is naturally upset that Patient A suffered immediate and ongoing trauma and distress as a result of the vaccination that he administered. He is sorry that Patient A was at A&E for 9 hours on 3 August 2021 whilst she was monitored and various tests undertaken.
 - xix. He did not return to work at this branch of Well Pharmacy following the incident being reported but he did work as a locum at other Well pharmacies in the Plymouth/Devon area for the next couple of years.
- h. A reflective statement from the Registrant which sets out in pertinent part:

“I was put under pressure to provide a service for which I was not trained for. But as the Responsible Pharmacist the final decision is mine

alone. I shouldn't have undertaken the service at all. I take responsibility for my actions. In future I assure you that nothing like this would happen again.

[...]

I felt very stressed out and worn out and out of my comfort zone. I should have at this point stepped back and assessed the situation to see if there was any other way out.

I apologize unreservedly to the mother of the child for this situation. I should have asked a colleague Pharmacist for a second opinion.

[...]

I felt in my guts that something was wrong. I did not feel in control of the situation.

[...]

I thought that I should find and read the SOP for the service first.

[...]

I wish I never agreed to provide the service due to no prior training been provided. I will ensure in the future that a situation like this never arises again. I will ask for advice from another Pharmacist or report the situation to the Area Manager for intervention.

[...]

I have since this experience undertaken all training to be able to deliver a chicken pox vaccine in the future. But I have also learnt not to be pressured into providing a service I have not undertaken before until I have done the full training.

I failed in my duty of care to my patient and I will ensure in the future that something like this never happens again in the future.

I am using this incident as a learning curve to be able to look back on this event in decision making in the future.

[...]

I should have re-directed the patient to another store where a fully trained Pharmacist could have undertaken the service safely."

Decision on Facts

24. The Registrant admitted all allegations. By the application of Rule 31(6), the admitted factual allegations, allegations 1-3, were found proved.

Evidence on Grounds and Impairment

25. In addition to the evidence the Registrant provided in paragraphs 23(g) and 23(h), the Registrant provided the following oral evidence:
- a. He has been a pharmacist for 24 years.
 - b. He is currently working for Boots as a locum pharmacist.
 - c. He first knew about the vaccination being administered on 2 August 2021. He spoke to Patient A's mother on 2 August 2021 and explained to her that he was seeking an alternative vaccine.
 - d. The BNF said that Zostavax is listed as a chicken pox vaccine. He did not check the BNF further, in that the BNF said that the vaccine was only for older people.
 - e. He ordered Zostavax and did not read the PGD. The staff at the Pharmacy did not know where the PGD was, so he could not check it prior to administering the vaccine.
 - f. He administered Zostavax to Patient A, a child. He inserted the needle of the vaccine on more than one occasion into Patient A, due to encountering difficulties as he had never administered a vaccination to a child previously.
 - g. He did not check Patient A's details with Patient A's mother as the information was already on his computer and he knew it was them as he saw them the day before. He did not explain any of the warnings about the vaccine on 3 August 2021 as he thought the vaccine was safe and the Zostavax vaccine and Varivax vaccine were the same vaccine, other than branding.
 - h. He punctured the skin of Patient A at least twice as the skin of a child is different to that of an adult, and he was not used to vaccinating a child.
 - i. He administered a vaccine that he was not competent to administer. He should not have done so and he should have cancelled the booking. He was the responsible pharmacist on the day.
 - j. If the situation occurred again, he would tell the manager and cancel the booking. He felt pressured by the Pharmacy staff. If he had refused to undertake the vaccination of Patient A, the Pharmacy would have cancelled his future bookings as a locum, which he could not afford to happen.
 - k. The previous pharmacist at the Pharmacy had been there for five years and had provided the chicken pox vaccine service. The Pharmacy should have cancelled the chicken pox vaccination programme when the previous pharmacist left.

- l. The manager of the Pharmacy left the week before he administered the chicken pox vaccine to Patient A. He was put under pressure by the pharmacy dispensers (who were acting as the manager of the Pharmacy) to administer the vaccine. He should have cancelled the booking and walked out of the Pharmacy. He regrets not doing that.
- m. He thought he had control of the situation when administering the vaccine, and thought it was safe to do so as the Zostavax vaccine and Varivax vaccine were the same vaccine, other than branding.
- n. He would not feel happy being administered a vaccine by an individual who was not trained to administer it.
- o. Since administering Zostavax to Patient A, he has undertaken training to administer the chicken pox vaccine, but has not done so in practice.
- p. He has not vaccinated a child since administering Zostavax to Patient A.
- q. He is trained to administer the flu vaccination and has administered hundreds since he was trained to do so.
- r. The present allegations are the only concerns that he has had during his career.
- s. He supports his wife and daughter who live in Ghana.
- t. He is very sorry and accepts responsibility for what happened.
- u. He has done “plenty” of CPD which is on the “GPhC website”.

Submissions on Grounds and Impairment

- 26. Having found particulars of allegation proved, the Committee went on to consider whether the allegations amounted to the ground of misconduct and, if so, whether the Registrant’s fitness to practise is currently impaired.
- 27. In relation to misconduct, on behalf of the Council, Mr Choudry submitted that:
 - a. The Registrant’s administration of an inappropriate vaccine to a vulnerable child, without informed consent, proper checks, or necessary competence, directly engages public protection concerns and undermines public confidence. This conduct is consistent with past determinations of misconduct where unsafe practice, disregard for professional guidance, and failure to respect patient safety have been central. The seriousness of these breaches, compounded by risks to a patient and the public interest demonstrate misconduct.
 - b. The behaviour of the Registrant amounts to misconduct. It involves multiple serious breaches of fundamental professional standards and is *“conduct which would be regarded as deplorable by fellow practitioners”*.

- c. The Registrant has breached standards 1, 4 and 5 of the Standards for pharmacy professionals dated May 2017 (“Standards”):

Standard 1: Pharmacy professionals must provide person centred care

- d. This standard requires pharmacy professionals to tailor care to the individual needs and circumstances of the patient. The Registrant did not obtain valid, informed consent from Ms Person A on behalf of Patient A prior to administering Zostavax vaccine. Person centred care requires actively involving the patient or a parent or guardian for children in decisions about their health and providing all relevant information in a way they can understand. The Registrant did not provide Ms Person A with an explanation of the vaccination, including its risks. Standard 1 expects pharmacy professionals to ensure the person has all necessary information to make an informed choice. Ms Person A booked the vaccine for chickenpox but the Registrant failed to address the specific request, needs and expectations for her child. The Registrant did not confirm Patient A’s name or date of birth before administering the vaccination, risking harm and showing disregard for individual circumstances of Patient A. By administering Zostavax (intended for shingles in adults, not children) shows the Registrant failed to tailor treatment to needs of Patient A, putting her safety and well-being at risk.

Standard 4: Pharmacy Professionals must maintain, develop and use their professional knowledge and skills

- e. The Registrant failed to recognise his limits of knowledge and skills by administering Zostavax – a vaccine intended for shingles in adults, to a 2-year-old child outside of clinical guidelines and not being covered by a PGD. This demonstrates a failure to recognise and work within the limits of their knowledge and competence. The Registrant did not review the PGD for the intended vaccination before the appointment and administered the vaccine that was unsuitable for the age and reason for the vaccine. Standard 4 requires pharmacy professionals to use current evidence-based knowledge to deliver safe care. The Registrant was not trained or authorised to administer the Zostavax or Varivax vaccine, which put the safety of Patient A at risk. Pharmacy professionals are expected to ensure they have the appropriate skills and learning for the activities they undertake.

Standard 5: Pharmacy Professionals must use their professional judgement

- f. Failure to make patient’s best interests the first concern: The Registrant administered Zostavax, a vaccine for shingles in adults, to a 2-year-old child for whom it was not clinically indicated, and did so without proper authority, patient information, or checks. This demonstrates a clear lack of prioritising the patient’s best interests and safety.
- g. Failure to use clinical and professional judgment: By not verifying the patient’s identity, not checking clinical guidelines or the PGD, and delivering a vaccine

outside of competence and legal/clinical remit, the Registrant failed to make considered decisions or seek advice where appropriate. It was a prescription only vaccine and the Registrant is not an independent prescriber. Standard 5 requires professionals to use their judgment to make or guide decisions, especially in situations of clinical uncertainty or when responsibilities may conflict.

- h. Not recognising the limits of competence: The Registrant failed to appreciate when to refer to others or seek assistance, a core expectation of sound professional judgment. He did not have the required training nor was he an independent prescriber. Acceptable professional judgment depends on having all relevant information. The registrant administered a vaccine without having the critical facts, patient's correct age, correct medication, relevant guidance, and consent. He did not check the PGD or look further into the Zostavax vaccine.
28. In relation to misconduct, on behalf of the Registrant, Mr Haines submitted that it is a matter for the Committee whether the Registrant's conduct fell into the category of misconduct.
29. In relation to current impairment, on behalf of the Council, Mr Choudry applied Rule 5(2) of the GPhC Fitness to Practise Rules 2010, and submitted that:
- a. Presents an actual or potential risk to patients or to the public: The administration of Zostavax, a vaccine unlicensed and unsuitable for children, to a 2-year-old patient amounted to a real risk of serious physical harm and distress. Failure to verify patient details, follow PGDs, or act within competence continues to raise concerns of potential risk of future errors despite some training completed. Limited and inconsistent insight into the incident and partial deflection of responsibility sustain the risk of repetition.
 - b. Has brought or might bring the profession of pharmacy into disrepute: The Registrant's conduct and inadequate accountability, especially involving a vulnerable child and prescription-only medication given without prescription, seriously undermine public confidence in pharmacy professionals. Continued defensive stance and shifting blame threaten to damage the profession's reputation and standing.
 - c. Has breached one of the fundamental principles of the profession of pharmacy: The Registrant has breached the fundamental principles of maintaining patient safety, acting within competence, and taking responsibility.
 - d. Despite some progress in reflection and remediation, the lack of full acceptance of responsibility and comprehensive understanding justifies a finding of impairment to ensure ongoing public protection and maintenance of professional standards. The following are examples of where the Registrant was still lacking insight:
 - i. The Registrant has not addressed why he would not be in control as the responsible pharmacist.

- ii. He placed more concern on the pressure by the Pharmacy over patient safety and how the public would feel about an untrained person administering a vaccine.
 - iii. He provided little reflection upon any of the other allegations.
 - iv. It is concerning that the Registrant still claims that the Zostavax and Varivax vaccines are medically the same, when they are different vaccines for different patient age ranges.
 - v. There is limited evidence of his completed CPD.
- 30. In relation to current impairment, on behalf of the Registrant, Mr Haines submitted that:
 - a. The Registrant may have presented a risk at the time of the allegations, albeit only to Patient A in isolation. There was no other issue with his practice.
 - b. At present, the Registrant does have insight given that he is clear that he should not have administered the Zostavax vaccine to Patient A, which was a poor error of judgement.
 - c. There has been no repetition of a similar incident.
 - d. He has undertaken a relevant vaccination course. Although should he be asked to administer a chicken pox vaccine in the future, it is something that he would give serious thought to.
 - e. He has owned the situation.
 - f. It is unlikely that the pharmacy profession or the public would feel the need for current impairment to be found.

Decision on Grounds

- 31. The Committee took account of the guidance given to the meaning of “*fitness to practise*” in the Council’s publication “*Good decision-making*” (Revised March 2024).
- 32. The Committee accepted and applied the following definition of “*misconduct*”:

“...some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word ‘professional’ which links the misconduct to the profession. Secondly, the misconduct is qualified by the word ‘serious’. It is not any professional misconduct which will qualify. The professional misconduct must be serious.”

33. The Committee also took into account the observation of J Collins in *Nandi v GMC [2004] EWHC 2317 (Admin)* that: “The adjective ‘serious’ must be given its proper weight and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners.”
34. The Committee considered that by committing the conduct set out in the allegations, the Registrant fell short of what would be proper in the circumstances, and would be regarded as deplorable by fellow practitioners, in that he:
- a. Did not, with Patient A and her mother:
 - i. Check Patient A’s name;
 - ii. Check Patient A’s date of birth;
 - iii. Obtain informed consent of the vaccine being administered; and
 - iv. Set out the risks of the vaccine.
 - b. Ordered, and then administered, a vaccine which was unsuitable to Patient A.
 - c. Did not follow the PGD or BNF when reconstituting and administering the vaccine to Patient A, inserting the needle which reconstituted the vaccine into the skin of Patient A on two or more occasions.
 - d. Failed to make an adequate record of their appointment.
35. Further, such actions damage public confidence in the profession, as it would convey a degree of opprobrium to the ordinary intelligent citizen (*Shaw v General Osteopathic Council [2015] EWHC 2721 (Admin)*).
36. The Committee considered whether the Registrant had breached any of the Standards. The Committee determined that there had been a breach of Standards 1, 4, and 5 as a result of the misconduct, as set out in paragraphs 27(c) – 27(h) above. However, the Committee also consider that the Registrant breached the following standards:
- a. Standard 3 – Pharmacy professionals must communicate effectively. In particular:
 - i. communicate effectively with others involved in the care of the person. The Registrant failed to communicate effectively to Patient A’s mother for the reasons set out at paragraph 34(a) above.
 - b. Standard 8 – Pharmacy professionals must speak up when things go wrong. In particular:
 - i. challenge poor practice and behaviours. The Registrant sets out that he was put under pressure by the Pharmacy to administer the vaccine. He knew that he was not competent to do so and should have challenged the Pharmacy’s pressure, especially as he was the responsible pharmacist.
 - c. Standard 9 – Pharmacy professionals must demonstrate leadership. In particular:

- i. assess the risks in the care they provide and do everything they can to keep these risks as low as possible. The Registrant sets out that he was put under pressure by the Pharmacy to administer the vaccine. He knew that he was not competent to do so and should not have done so in order to keep the risks to patients as low as possible.
- 37. The Committee bore in mind that the Standards may be taken into account when considering the issues of grounds and impairment but that a breach of the Standards does not automatically establish that the Registrant's fitness to practise is impaired (Rule 24(11)).
- 38. Accordingly, the Committee concluded that, in its judgement, the grounds of misconduct are established.

Decision on Impairment

- 39. Having found that the particulars of allegation amounted misconduct, the Committee went on to consider whether the Registrant's fitness to practise is currently impaired.
- 40. At the outset, the Committee considered the Registrant's insight and remediation.
- 41. The Committee considers that the Registrant has shown some insight given he has admitted to the allegations and apologised for administering the vaccine to Patient A. However, the Committee considers that the Registrant's insight is only limited, as in the four years since the conduct set out in the allegations:
 - a. He has provided limited reflection as to the potential harm that his actions could have caused. He has not reflected on what would have happened if Patient A fell more seriously unwell following his administering of the vaccine.
 - b. Although he has apologised to Patient A, he has not:
 - i. Reflected on the other allegations to which he has admitted.
 - ii. Not reflected on the facts that he should not have administered the vaccine if he could not find the PGD (and therefore had something to fall back upon should any risks materialise).
 - c. He still maintains the position that the Zostavax and Varivax vaccines are medically the same, when they are different vaccines for different patient age ranges.
- 42. The Committee considered that the Registrant has completed some remediation, given he has completed training to administer a chicken pox vaccine. However, the Committee considers the remediation to be limited given:
 - a. It has seen limited remediation concerning the other allegations such as ensuring that the vaccination recipient details are correct, and that the risks of any vaccine are fully explained.

- b. It has seen limited remediation concerning the Registrant's leadership and ability to withstand pressure to act outside his competence, should such a situation arise again in the future.
 - c. No evidence of CPD completed concerning the issues raised in the allegations.
 - d. The Registrant has said that if he had refused to administer the vaccine to Patient A, he would have lost future bookings with the Pharmacy. The Committee has not seen evidence from the Registrant that, in the future, the Registrant would put patients first, rather than his own interest.
43. The Committee considered whether the particulars found proved show that actions of the Registrant:
- a. present an actual or potential risk to patients or to the public;
 - b. have brought, or might bring, the profession of pharmacy into disrepute;
 - c. have breached one of the fundamental principles of the profession of pharmacy;
or
 - d. mean that the integrity of the Registrant can no longer be relied upon.

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

44. The Committee considers that the Registrant's conduct and behaviour presented an actual risk of harm to patients and the public. The Registrant administered a vaccine without checking the patient's name and date of birth immediately prior to administering it. Consequently, the vaccine could have been administered to the wrong person. The Registrant failed to explain the risks of the vaccine to Patient A's mother. Consequently, Patient A's mother was not fully apprised of the risks of the vaccine. The Registrant inserted the needle which reconstituted the vaccine into the skin of Patient A on two or more occasions, causing unnecessary harm to Patient A. The Registrant failed to make an adequate record of Patient A's appointment. Poor recordkeeping poses a risk to patients. The Registrant failed to review the PGD prior to administering the vaccine. The PGD is likely to have contained important information relevant to the vaccine. A failure to review the PGD presented a potential risk to Patient A.
45. Given the limited insight and lack of remediation completed by the Registrant, as set out in paragraphs 41-42 above, the Committee considers that the Registrant's conduct or behaviour may be repeated, which presents an actual or potential risk to patients or to the public. In particular, the Committee was concerned that as at the date of this Principal Hearing, the Registrant maintains the position that the Zostavax and Varivax vaccines are medically the same, when they are different vaccines for different patient age ranges.

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

46. The Committee considered that the Registrant's misconduct, as set out in the allegations, has brought the profession of pharmacy into disrepute. The Registrant acted outside of his competencies, administered prescription-only medication to a child without prescription, and placed his own interest above that of a patient (The Registrant has said that if he had refused to administer the vaccine to Patient A, he would have lost future bookings with the Pharmacy). The Registrant's actions undermine public confidence in pharmacy professionals.
47. Given the limited insight and lack of remediation completed by the Registrant, as set out in paragraphs 41-42 above, the Committee considers that the Registrant's conduct or behaviour might bring the profession of pharmacy into disrepute in the future.

Whether the Registrant's conduct or behaviour has breached one of the fundamental principles of the profession of Pharmacy

48. The Committee considered that the Registrant's conduct, as set out in the allegations, has breached more than one of the fundamental principles of the profession of pharmacy, namely the failure to: act within competence, take responsibility for actions, and ensuring patient-centred care (including safety and placing the needs of the patient above your own).
49. Given the limited insight and lack of remediation completed by the Registrant, as set out in paragraphs 41-42 above, the Committee considers that the Registrant's conduct or behaviour might breach one of the fundamental principles of the pharmacy profession in the future.

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

50. The Committee does not consider this matter, and the allegations, to constitute a case of where the integrity of the Registrant can no longer be relied upon.

Committee's conclusion on impairment

51. In light of the above, the Committee considered the Registrant's fitness to practise to be impaired on the personal element.
52. Further, members of the public would be appalled to learn that a pharmacist had conducted the actions set out in the proven allegations, with limited insight and remediation of these allegations. Consequently, the Committee considered the Registrant's fitness to practise to be impaired on the wider public interest element, namely maintaining public confidence in the pharmacy profession and upholding professional standards.

Outcome

53. Having found impairment, the Committee has gone on to consider the matter of outcome. The Committee's powers are set out in Article 54(2) of the Pharmacy Order 2010. 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.
54. 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 in the profession and to promote professional standards. The Committee is therefore entitled to give greater weight to the public interest over the Registrant's interests.
55. The Committee had regard to the Council's *"Good decision making: Fitness to practise hearings and outcomes guidance"*, published in March 2024 ("Guidance"), to inform its decision.
56. On behalf of the Council, Mr Choudry submitted:
 - a. The following can be considered as aggravating factors:
 - i. The conduct was against a child, who has now developed a phobia of needles;
 - ii. The quantity of deliberate breaches of standards and incorrect clinical decisions;
 - iii. Inadequate recordkeeping;
 - iv. Lack of reflection on other allegations;
 - v. Incomplete insight and remediation; and
 - vi. The serious risks to patient safety posed by this type of conduct.
 - b. The Registrant having no previous regulatory findings against him with the Council can be considered as mitigating factor.
 - c. The reflection and completion certificate of a vaccination course indicates that the Registrant has begun to develop insight into the seriousness of the incident and the importance of vaccination protocols. He acknowledges that he should have sought a second opinion, which shows a positive step towards recognising limits and appropriate action. However, the reflection contains inaccuracies, notably the claim that Zostavax was an alternative chickenpox vaccine, which it is not, demonstrating ongoing gaps in clinical understanding. It also fails to address the other aspects of his misconduct, such as his failure to ask appropriate questions before the administration of the vaccine, or his decision to act out of scope of

practise despite his apparent concerns. It remains a concern that the Registrant continues to deflect responsibility towards his ex-colleagues.

- d. Given the seriousness of the conduct, the appropriate sanction is a suspension from practise for 12 months. A period of suspension for this amount of time will mark the seriousness of the Registrant's misconduct, while also providing him with an opportunity to remediate and gain sufficient insight into his actions, thereby ensuring that a message is sent to the public, the profession and the Registrant that professional standards are maintained, and the risk to the public is minimised.

57. On behalf of the Registrant, Mr Haines made the following submissions:

- a. The following can be considered as mitigating factors:
 - i. The Registrant is of previous positive good character and has no earlier findings recorded against him.
 - ii. He has cooperated with the Regulator and Committees throughout the whole process.
 - iii. He has an unblemished professional record to date spanning some 24 years.
 - iv. The originating act(s) giving rise to the admitted allegations occurred over four years ago.
 - v. The originating act(s) concerning the Registrant represents a *"one-off"* isolated incident.
 - vi. The admitted allegations arose out of a set of circumstances unlikely to arise again. There has been no repetition, and no further concerns of any kind have arisen with regard to the Registrant's working practice.
 - vii. The Registrant has worked unfettered since the allegations were raised.
 - viii. He has shown understanding and insight by virtue of his written reflection and evidence.
 - ix. He can put forward positive references on his behalf which show that he works well.
 - x. His admissions to the Committee at the start of the hearing.
 - xi. The Registrant has successfully completed the relevant chickenpox vaccination training (albeit he has not as yet put this into practice).
 - xii. He continues to perform flu vaccinations without difficulty or concerns being raised.
- b. The public interest can be served by the need to keep otherwise competent pharmacists working so that they may serve the public they have been trained to help and give advice.

- c. *“No further action”* is an outcome open to the Committee. It would be open to any committee to state that the rigorous and lengthy disciplinary process was sufficient to mark the circumstances of this case.
 - d. a *“warning”* would be a meaningful sanction to be applied and would fulfil the needs of an informed public and/or profession. The Registrant has had a 24-year unblemished career and has worked unfettered for the past 4 years. There has been no suggestion of any other concerns during the Registrant’s career. He has completed the chicken pox vaccine training and continues to administer flu vaccines. This restriction would adequately reflect the needs of the public and profession having taken into account the particular circumstances of his case and the personal mitigation that the Registrant puts forward. A warning if imposed would appear on the Council’s register and can be seen by the Registrant, the Profession and the Public.
 - e. Should the Committee not be minded to follow the suggestion above then it must next consider imposing conditions. The Registrant has continued to work unfettered during the fitness to practise process and his work is free of any further concerns, including administering flu vaccines.
 - f. A suspension is not needed in this case. However, if this is the view of this Committee then we ask that the Committee are reminded that they should start with the shortest possible period of suspension as they consider appropriate and not adopt the period of time suggested by the Council.
 - g. A removal is not necessary in this case. Such a sanction would not represent a proportionate response. The Committee will be reminded of its 2024 guidance document which states that removal is reserved for the *“most serious cases”*. Whilst all cases before the Committee must inherently be serious it is advanced that this case is not *“the most serious case”* and as such removal is not necessary.
58. The Committee considered the following to be aggravating factors in this case:
- a. The subject of the Registrant’s misconduct was a child, who has suffered direct harm;
 - b. The Registrant administered a vaccine to Patient A without adequate information concerning the patient and vaccine;
 - c. The Registrant has breached a number of the Standards
 - d. The Registrant has put his own interests above that of his patients; and
 - e. Despite four years passing, the Registrant’s insight and remediation is limited, as set out in paragraphs 41 and 42 above.
59. The Committee considered the following to be mitigating factors in this case:
- a. The misconduct at the heart of the allegations stemmed from a one-off incident;

- b. The Registrant has offered some apology and shown remorse;
 - c. The Registrant has practised without restriction for the past four years during the fitness to practise process;
 - d. The Registrant has obtained positive professional references;
 - e. The Registrant has undertaken training concerning the administering of the chicken pox vaccine;
 - f. The Registrant admitted to all the allegations; and
 - g. The Registrant has no previous regulatory findings against him with the Council and has an otherwise unblemished 24-year career as a pharmacist.
60. The Committee considers that the Registrant's proven misconduct, coupled with the demonstrating limited insight and no remediation, makes taking no action or imposing a warning insufficient to protect the public. Further, these outcomes would not adequately meet the wider public interest of maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour. Therefore, the Committee finds that taking no action or issuing a warning to be inappropriate.
61. The Committee next considered the imposition of conditions of registration on the Registrant. Although the Committee considered that the misconduct at the heart of the allegations stemmed from a one-off incident, the misconduct exposed further concerns of the Registrant, some of which the Committee consider to be attitudinal:
- a. The Registrant failed to stamp his authority as a responsible pharmacist;
 - b. The Registrant felt pressured into administering a vaccine for which he was not trained or competent to administer;
 - c. The Registrant failed to ask for help when he was in a difficult situation;
 - d. The Registrant's recordkeeping was exposed in that he failed to make a record of the appointment; and
 - e. The Registrant's safeguarding was exposed in that on the day of the vaccine, he failed to confirm the Patient's name, date of birth, confirm the correct vaccine, explain the risks of the vaccine, and read or follow the PGD.
62. Consequently, the Committee considered that no relevant or proportionate conditions could be formulated to mitigate risk from the Registrant repeating his misconduct, given:
- a. There are no appropriate or measurable conditions which could address the underlying behaviour stemming from the allegations, some of which is attitudinal;
 - b. There are no appropriate or measurable conditions which could mitigate the risks posed by the Registrant; and

- c. His limited insight and remediation.

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

- 63. The Committee next considered whether suspension would be an appropriate and proportionate outcome. The Committee noted the Council's Guidance concerning suspension:

"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."

- 64. In light of the Council's Guidance, the Committee considered that suspension would be appropriate, and in the wider public interest, given:

- a. 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, as set out in paragraphs 60-62 above.
- b. For the reasons set out in paragraph 61, 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.
- c. Public confidence in the profession demands no lesser outcome.

- 65. The Committee considered that a suspension, for a period of four months, is appropriate and proportionate to mark the seriousness of the Registrant's actions, as set out in allegations, and the exposed further concerns set out at paragraph 61 above.

- 66. The Committee considered that, although the Registrant has demonstrated limited insight and remediation, this can be developed should the Registrant wish to do so. The Committee considered that any future committee reviewing the suspension would be assisted by the following actions from the Registrant:

- a. A submission of a reflective piece in which the Registrant covers:
 - i. How he puts patients first;
 - ii. How he deals with pressurised situations;
 - iii. The strategies that he uses to ensure patient safety in difficult situations;
 - iv. The importance of accurate recordkeeping; and
 - v. How he safeguards patients when administering a vaccine.

- b. Learning/training which covers the following areas:
 - i. Leadership;
 - ii. The role of a responsible pharmacist; and
 - iii. Safeguarding training for children.
- 67. The Committee considers that the recommended actions as set out at paragraph 66 above would go a long way to developing the Registrant's insight and completing his remediation, which in turn, would reduce any risk of repetition of similar incidents. The Committee considers that a period of four months would give the Registrant sufficient time to complete the recommended actions as set out at paragraph 66 above.
- 68. The Committee considered removal of the Registrant to be unnecessary and disproportionate. Removal would deprive the public of a pharmacist whose misconduct is remediable and has received good references for his pharmacy work.
- 69. The Committee therefore directs that the Registrant is suspended from the Council's Register for a period of four months. The Suspension Order will be reviewed prior to its expiry.

Decision on Interim Measures

- 70. Mr Choudry made an application for an interim measure of suspension to be imposed on the Registrant's registration, to take effect from today's date, pursuant to Article 60 of the Pharmacy Order 2010, pending the coming into force of the Committee's substantive order. He submitted that an interim measure would be consistent with the substantive order imposed by the Committee.
- 71. On behalf of the Registrant, Mr Haines submitted that no interim measures are necessary on the basis that the Registrant has worked unfettered for the past four years and the additional time would allow the Registrant to put his affairs in order.
- 72. In considering Mr Choudry's application, the Committee took account of the fact that its decision to suspend the Registrant from the Council register will not take effect until 28 days after the Registrant is formally notified of the outcome, or until any appeal is concluded.
- 73. The Committee has found that there remains a risk that the Registrant might repeat his conduct, if permitted to return to work unrestricted. For the reasons set out in this decision, the Registrant's unrestricted registration would place patients and the public at risk of harm and have an impact on public confidence and upholding standards. The Committee is satisfied that it is necessary for an interim measure to be put in place to protect the public and safeguard the public interest during the appeal period.

74. The Committee is satisfied that it is therefore appropriate for an interim measure to be in place prior to the taking effect of the substantive order.
75. The Committee hereby orders that the entry of the Registrant in the register be suspended forthwith, pending the coming into force of the substantive order.
76. This concludes the determination.