

General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote video link hearing

3 – 10 February 2026

Registrant name:	Kaleem Ahmad
Registration number:	2061614
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Rachel Forster (Chair) Jignesh Patel (Registrant member) Shaun Donnellan (Lay member)
Legal Adviser:	Adam Smith
Committee Secretary:	Gemma Staplehurst
Registrant's Legal Representative:	Rebecca Paterson
General Pharmaceutical Council:	Matthew Corrie, Case Presenter
Facts proved by admission:	All
Fitness to practise:	Impaired
Outcome:	Suspension, 3 months with review
Interim measures:	Interim suspension

Any decision including any finding of facts, impairment and outcome 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 10 March 2026 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, and being the Superintendent Pharmacist and/or regular Responsible Pharmacist and/or a Director of Richmond Healthcare (Stechford Limited), trading as A+ Pharmacy, 311 Bordesley Green East, Stechford, Birmingham, B33 8QF (“the Pharmacy”):

1. Between approximately 1 April 2021 – 30 June 2021, supplied pharmacy-only (“P”) medicine to patients via the eBay platform, in circumstances where you did not have adequate procedures and/or adequate systems in place to ensure the safe supply of the medication to patients in that you:

*1.1. You failed to carry out any adequate risk assessment in relation to the supply of medicines via Ebay; **Admitted***

*1.2. You failed to ensure that you had any, or any adequate, process in place to verify the identity of patients; **Admitted***

*1.3. You failed to ensure that any, or any sufficient, information to assess the suitability of the medication was obtained from patients in advance of medication being supplied; **Admitted***

*1.4. You failed to have in place any, or any adequate, process to prevent inappropriate supplies and/or excessive supply and/or multiple supplies to the same patients. **Admitted***

2. In approximately June 2021, entered into agreement with EU Meds Limited (“EU Meds”) to dispense against private prescriptions supplied by EU Meds, in circumstances where:

*2.1. The EU Meds prescriber, Person B, was not registered with a UK healthcare and/or a healthcare professional regulator; **Admitted***

*2.2. EU Meds was not registered with a UK healthcare regulator; **Admitted***

2.3. You failed to carry out any, or any adequate, independent verification that Person B was registered in his home country and/or whether he could lawfully issue prescriptions online to UK based patients; **Admitted**

2.4. You failed to carry out any, or any adequate, risk assessment in relation to working with a prescribing service and/or a prescriber not registered in or based in the UK; **Admitted**

2.5. You failed to ensure that the EU Meds prescriber(s) were prescribing in accordance with UK prescribing guidance; **Admitted**

2.6. You failed to carry out an adequate risk assessment of the risks associated with dispensing medicines, which were primarily medicines liable to abuse, misuse or overuse. **Admitted**

3. Between approximately 1 June 2021 – 26 July 2021, failed to carry out an adequate risk assessment and/or an adequate audit of the EU Meds service in that:

3.1. You were not aware of the measures EU Meds had in place to prevent over-ordering of high-risk medicines and/or repeat requests being supplied to patients; **Admitted**

3.2. You did not routinely review the prescribing decisions and/or make clinical interventions; **Admitted**

3.3. You failed to adequately check the identity checking procedures in place and/or being carried out by EU Meds; **Admitted**

3.4. You failed to adequately check the procedures in place by EU Meds for the delivery of the medication to a patient and/or the return of any medication for disposal. **Admitted**

4. Between approximately 1 June 2021 – 26 July 2021, dispensed high-risk medicines

liable to abuse, misuse or overuse, in circumstances in which you:

...

*4.2. Failed to undertake adequate checks of all the necessary information to ensure that the supplies made were clinically appropriate and safe for patients; **Admitted***

*4.3. Failed to undertake adequate checks and/or ensure EU Meds prescribers had contacted the patients' GP and/or ensure other treating healthcare professionals involved in the patients' care were consulted before any supply was made; **Admitted***

*4.4. Failed to ensure that adequate standard operating procedures were in place in respect of the EU Meds dispensing service; **Admitted***

*4.5. Failed to make one or more an adequate record(s) in the private prescription record of one or more supplies. **Admitted***

5. On or about 28 May 2022, caused and/or allowed and/or permitted the supply of a P medication, namely Fluconazole to Person A, from the Pharmacy, at a distance via the Amazon store, in the absence of:

*5.1. Any, or any sufficient information in relation to Patient A to assess the suitability of the medication supplied; **Admitted***

*5.2. Any, or any adequate, dialogue with Person A prior to the supply, in terms of one or more the 'WWHAM' questions; and/or **Admitted***

*5.3. any, or any adequate, supervision by a pharmacist. **Admitted***

By reason of the matters above your fitness to practise is impaired by reason of your misconduct."

Documentation

Document 1 - GPhC Bundle - Principal Hearing (Redacted)

Document 2 – GPhC’s Statement of Case

Document 3 – Registrant’s Statement of Case

Document 4 - Registrant's bundle

Document 5 - Registrant's bundle amended

Document 6 –Ebay sales data extract, submitted by Registrant

Document 7 – Screenshot of messages between JW, OS & A Plus Pharmacy submitted by Registrant

Document 8 – Investigating Committee response, submitted by Registrant

Document 9 - Relevant SOPs, a protocol for the sale of medicines, a SOP signing sheet and a photograph of the SOP folder, submitted by Registrant

Determination

Introduction

1. This is the written determination of the Fitness to Practise Committee at the General Pharmaceutical Council ('the Council').
2. This hearing is governed by *The Pharmacy Order 2010* ('the Order') and *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010* ('the Rules').
3. The statutory overarching objectives for these regulatory proceedings are:
 - To protect, promote and maintain the health, safety and well-being of the public;
 - To promote and maintain public confidence in the professions regulated by the Council; and

- 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.

Preliminary Issues

Service of Notice of Hearing

6. The Committee considered the service of the Notice of Hearing. No issue was taken by either party as to service and all parties had attended and were represented.
7. The Committee was satisfied that there had been good service of the Notice of Hearing ('Notice') in accordance with Rules 3 and 16 of the Rules.

Application to amend the particulars of allegation

8. The Committee heard an oral application by Mr Corrie to amend the allegations set out in the Notice of Hearing against the Registrant under Rule 41 of the General

Pharmaceutical Council (Fitness to Practise and Disqualification, etc Rules) Order of Council 2010 (**'the Rules'**).

9. The allegation as contained within the Notice of Hearing was as follows:

"You, a registered pharmacist, and being the Superintendent Pharmacist and/or regular Responsible Pharmacist and/or a Director of Richmond Healthcare (Stechford Limited), trading as A+ Pharmacy, 311 Bordesley Green East, Stechford, Birmingham, B33 8QF ("the Pharmacy"):

1. Between approximately 1 April 2021 – 30 June 2021, supplied pharmacy-only ("P") medicine to patients via the eBay platform, in circumstances where you did not have adequate procedures and/or adequate systems in place to ensure the safe supply of the medication to patients in that you:

1.1. You failed to carry out any adequate risk assessment in relation to the supply of medicines via Ebay;

1.2. You failed to ensure that you had any, or any adequate, process in place to verify the identity of patients;

1.3. You failed to ensure that any, or any sufficient, information to assess the suitability of the medication was obtained from patients in advance of medication being supplied;

1.4. You failed to have in place any, or any adequate, process to prevent inappropriate supplies and/or excessive supply and/or multiple supplies to the same patients.

2. In approximately June 2021, entered into agreement with EU Meds Limited ("EU Meds") to dispense against private prescriptions supplied by EU Meds, in circumstances where:

2.1. The EU Meds prescriber, Person B, was not registered with a UK healthcare and/or a healthcare professional regulator;

2.2. EU Meds was not registered with a UK healthcare regulator;

2.3. You failed to carry out any, or any adequate, independent verification that Person B was registered in his home country and/or whether he could lawfully issue prescriptions online to UK based patients;

2.4. You failed to carry out any, or any adequate, risk assessment in relation to working with a prescribing service and/or a prescriber not registered in or based in the UK;

2.5. You failed to ensure that the EU Meds prescriber(s) were prescribing in accordance with UK prescribing guidance;

2.6. You failed to carry out an adequate risk assessment of the risks associated with dispensing medicines, which were primarily medicines liable to abuse, misuse or overuse.

3. Between approximately 1 June 2021 – 26 July 2021, failed to carry out an adequate risk assessment and/or an adequate audit of the EU Meds service in that:

3.1. You were not aware of the measures EU Meds had in place to prevent over-ordering of high-risk medicines and/or repeat requests being supplied to patients;

3.2. You did not routinely review the prescribing decisions and/or make clinical interventions;

3.3. You failed to adequately check the identity checking procedures in place and/or being carried out by EU Meds;

3.4. You failed to adequately check the procedures in place by EU Meds for the delivery of the medication to a patient and/or the return of any medication for disposal.

4. Between approximately 1 June 2021 – 26 July 2021, dispensed high-risk medicines liable to abuse, misuse or overuse, in circumstances in which you:

- 4.1. Failed to make adequate clinical check of the prescriptions before dispensing;*
- 4.2. Failed to undertake adequate checks of all the necessary information to ensure that the supplies made were clinically appropriate and safe for patients;*
- 4.3. Failed to undertake adequate checks and/or ensure EU Meds prescribers had contacted the patients' GP and/or ensure other treating healthcare professionals involved in the patients' care were consulted before any supply was made;*
- 4.4. Failed to ensure that adequate standard operating procedures were in place in respect of the EU Meds dispensing service;*
- 4.5. Failed to make one or more an adequate record(s) in the private prescription record of one or more supplies.*

5. On or about 28 May 2022, caused and/or allowed and/or permitted the supply of a P medication, namely Fluconazole to Person A, from the Pharmacy, at a distance via the Amazon store, in the absence of:

- 5.1. Any, or any sufficient information in relation to Patient A to assess the suitability of the medication supplied;*
- 5.2. Any, or any adequate, dialogue with Person A prior to the supply, in terms of one or more the 'WWHAM' questions; and/or*
- 5.3. any, or any adequate, supervision by a pharmacist."*

- 10. The application sought to remove particular 4.1, and was not opposed by the Registrant. Mr Corrie explained that there was no additional mischief addressed by 4.1 that is not covered by particular 4.2.
- 11. The Committee was reminded of its inquisitorial role in proceedings, as set out in *Council for the Regulation of Healthcare Professionals v GMC and Ruscillo* [2005] 1 WLR 717.

12. The Committee accepted the advice of the Legal Adviser.
13. The Committee allowed the application. It considered that allegation 4.1 was a duplicate of 4.2 and that therefore could be removed without risking any under prosecution in this case.

Particulars of Allegation (after amendment)

“You, a registered pharmacist, and being the Superintendent Pharmacist and/or regular Responsible Pharmacist and/or a Director of Richmond Healthcare (Stechford Limited), trading as A+ Pharmacy, 311 Bordesley Green East, Stechford, Birmingham, B33 8QF (“the Pharmacy”):

1. Between approximately 1 April 2021 – 30 June 2021, supplied pharmacy-only (“P”) medicine to patients via the eBay platform, in circumstances where you did not have adequate procedures and/or adequate systems in place to ensure the safe supply of the medication to patients in that you:

1.1. You failed to carry out any adequate risk assessment in relation to the supply of medicines via Ebay;

1.2. You failed to ensure that you had any, or any adequate, process in place to verify the identity of patients;

1.3. You failed to ensure that any, or any sufficient, information to assess the suitability of the medication was obtained from patients in advance of medication being supplied;

1.4. You failed to have in place any, or any adequate, process to prevent inappropriate supplies and/or excessive supply and/or multiple supplies to the same patients.

2. In approximately June 2021, entered into agreement with EU Meds Limited (“EU Meds”) to dispense against private prescriptions supplied by EU Meds, in circumstances where:

2.1. The EU Meds prescriber, Person B, was not registered with a UK healthcare and/or a healthcare professional regulator;

2.2. EU Meds was not registered with a UK healthcare regulator;

2.3. You failed to carry out any, or any adequate, independent verification that Person B was registered in his home country and/or whether he could lawfully issue prescriptions online to UK based patients;

2.4. You failed to carry out any, or any adequate, risk assessment in relation to working with a prescribing service and/or a prescriber not registered in or based in the UK;

2.5. You failed to ensure that the EU Meds prescriber(s) were prescribing in accordance with UK prescribing guidance;

2.6. You failed to carry out an adequate risk assessment of the risks associated with dispensing medicines, which were primarily medicines liable to abuse, misuse or overuse.

3. Between approximately 1 June 2021 – 26 July 2021, failed to carry out an adequate risk assessment and/or an adequate audit of the EU Meds service in that:

3.1. You were not aware of the measures EU Meds had in place to prevent over-ordering of high-risk medicines and/or repeat requests being supplied to patients;

3.2. You did not routinely review the prescribing decisions and/or make clinical interventions;

3.3. You failed to adequately check the identity checking procedures in place and/or being carried out by EU Meds;

3.4. You failed to adequately check the procedures in place by EU Meds for the delivery of the medication to a patient and/or the return of any medication for disposal.

4. Between approximately 1 June 2021 – 26 July 2021, dispensed high-risk medicines

liable to abuse, misuse or overuse, in circumstances in which you:

...

4.2. Failed to undertake adequate checks of all the necessary information to ensure that the supplies made were clinically appropriate and safe for patients;

4.3. Failed to undertake adequate checks and/or ensure EU Meds prescribers had contacted the patients' GP and/or ensure other treating healthcare professionals involved in the patients' care were consulted before any supply was made;

4.4. Failed to ensure that adequate standard operating procedures were in place in respect of the EU Meds dispensing service;

4.5. Failed to make one or more an adequate record(s) in the private prescription record of one or more supplies.

5. On or about 28 May 2022, caused and/or allowed and/or permitted the supply of a P medication, namely Fluconazole to Person A, from the Pharmacy, at a distance via the Amazon store, in the absence of:

5.1. Any, or any sufficient information in relation to Patient A to assess the suitability of the medication supplied;

5.2. Any, or any adequate, dialogue with Person A prior to the supply, in terms of one or more the 'WWHAM' questions; and/or

5.3. any, or any adequate, supervision by a pharmacist.

By reason of the matters above your fitness to practise is impaired by reason of your misconduct."

Registrant's response to Particulars of allegation

14. The Registrant admitted the following particulars in full:

- 1.1, 1.2, 1.3
- 2.1, 2.2, 2.3, 2.4, 2.5, 2.6
- 3.1, 3.2, 3.3
- 4.2, 4.3, 4.4, 4.5
- 5.1, 5.2, 5.3

15. The Registrant admitted the following particulars on the following bases:

- 1.4: *“Allegation 1.4 is partially admitted. Mr Ahmed accepts he did not have adequate processes in place to prevent inappropriate or multiple supplies. He does not accept that he did not have processes to prevent an excessive supply.”*
- 3.4: *“Allegation 3.4 is admitted to the extent Mr Ahmed accepts he did not adequately check the procedures in place by EU Meds for the return of any medication for disposal.”*

16. Mr Corrie on behalf of the GPhC, clarified the references to “adequacy” in the charges by reference to the following Guidance:

- *“Standards for pharmacy professionals 2017”* (**‘Standards for Pharmacy Professionals’**)
- *“Standards for registered pharmacies 2018”* (**‘The Standards for Pharmacies’**)
- *“The GPhC Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet 2019 and 2022”* (**‘The Distance Guidance’**)

17. Mr Corrie indicated that no evidence would be called to gainsay the bases advanced. The Committee determined that the bases advanced reflected the true nature of the evidence in support of the particulars.
18. Pursuant to Rule 31(6), given that all the allegations had been admitted, the Committee found all allegations proven on the bases put forward.

Summary

19. The Registrant is, and was at the time of the allegations the Superintendent Pharmacist ('SI') regular Responsible Pharmacist ('RP') and director of Richmond Healthcare (Stechford Limited) trading as A+ Pharmacy ('the Pharmacy').
20. The Pharmacy is a community pharmacy situated in a row of local shops opposite a large healthcare centre. It dispenses NHS prescriptions and sells a range of over-the-counter medicines. The Pharmacy supplied pharmacy-only medicines ('P-Meds') in addition to General Sale List ('GSL') medicines. This is referred to as a "bricks and mortar Pharmacy".
21. In early 2021, the Pharmacy started an online business on Amazon and Ebay supplying P- Meds. In June 2021, the Pharmacy also started dispensing private prescriptions supplied by a company called EU Meds Ltd (EU Meds).
22. P-Meds should generally only be purchased from a pharmacy and in the presence of a pharmacist. Whilst P-Meds can legally be sold at a distance, the SI and Pharmacy Owner should risk assess the medicine and apply professional judgment when deciding whether they wish to do so. This would generally include asking questions in a "WWHAM¹" style, before supplying the medicine.

¹ WWHAM: "Who is the patient? What are the symptoms? How long have the symptoms been present? Action Taken? Medication being taken?"

23. Allegation 1 relates to supplying P-Meds via the Ebay platform; Allegations 2, 3 and 4 relate to the dispensing of medicines against private prescriptions provided by a company called EU Meds Limited (**'EU Meds'**); Allegation 5 relates to the supply of a P-Med via the Amazon platform.
24. In or around June 2021, the Group Operations Manager for Testerworld Ltd became aware of unusually large volumes of P-Meds being ordered by the Pharmacy. They commenced an investigation and were informed that the Pharmacy was an internet pharmacy which was selling goods on eBay.
25. The Testerworld Manager went onto eBay and typed in hydrocortisone cream 1% and saw that the Pharmacy was advertising the product for sale as a P-Med.
26. On 29 June 2021, Testerworld commenced a wider investigation and saw that the Pharmacy was selling other P-Meds. As a result, sales to the Pharmacy were restricted.
27. On 6 July 2021, employees of Testerworld, visited the Pharmacy and spoke to the Registrant. The Registrant said that he had various processes in place to protect patients such as warnings and that some medications had quantity restrictions. He also stated that there was a spreadsheet used to monitor unusual purchasing patterns.
28. The Registrant provided information about the eBay sales arrangement. He said that information was provided on eBay, including a safety warning, dosage instructions, and other information that would be on the medicine packaging. He noted that the total value of the 8884 items sold on eBay came to £50,803.99. A limited SOP was in place which set out that *"at the end of the day Pharmacist to review list of sales and cancel any orders which have requested excessive quantities"*.
29. The Registrant also provided an undated Risk Assessment for eBay/Amazon/Website Sale, which related to the sale of GSL and P-Meds only. It stated that P-Meds known to be abused will not be sold via this mechanism and that other items will have controlled sales and orders of excessive quantities cancelled.

Pharmacy Inspection 26 July 2021

30. In July 2021, the GPhC received anonymous intelligence from a member of the public in regard to the ease with which they had been able to purchase medication from EU Meds. The dispensing label on the medication was that of the Pharmacy.
31. On 26 July 2021 the GPhC inspectors undertook an inspection of the Pharmacy. During the inspection, the Registrant was present, and confirmed that he had been dispensing prescriptions for EU Meds. He provided invoices submitted to UK Meds which showed that he had dispensed 3629 prescriptions. These prescriptions included high risk medications liable to abuse, misuse and overuse such as zopiclone, zolpidem, diazepam and modafinil. The volume of prescribing equated to between 50 and 150 prescriptions a day, which was additional to the Pharmacy's dispensing of NHS prescriptions.
32. The Registrant told the inspector that he had started working with EU Meds in June 2021 after he had been approached by a third party introductory company. He told the inspectors that he had done some due diligence before agreeing to commence the service.
33. The Registrant's due diligence consisted of checking with the National Pharmacy Association ('NPA') whether the service was legal and reviewing information as to the legality of the prescriptions. The Registrant gave evidence that the advice he received from NPA was that he could dispense medications legally online. The Registrant said that the NPA was his 'go to' source for advice and provided his liability insurance. They confirmed that the service was legal and sign posted him to the GOV.uk website and their own guidance.

34. The Registrant informed the inspectors that his contacts at EU Meds were called Josh and Ashley and that they communicated via an online messaging system. If he had an issue with a prescription, he would contact Ashley who was not a pharmacist. The Registrant confirmed that he did not ever contact the prescriber directly.
35. The Registrant was asked if he had carried out a risk assessment, and was further questioned on the Distance Guidance 2019. The Registrant stated that he had asked EU Meds about identity checks, order frequency checks, and asked whether he could refuse to dispense a prescription. However, he said that he did not write anything down.
36. The Registrant is reported to have said that he had not read the Distance Guidance 2019 and that he was not aware of its existence.
37. Further, the Registrant was asked about whether he had checked the credentials of the prescriber. His response was that he had seen the material provided by EU Meds but when he googled it himself, he was unable to understand it because it was in German.
38. The Registrant told the inspectors that he had decided to take the service on and work with EU Meds to obtain additional funds. The Pharmacy received the drug tariff price (+10%) +£3.50 per prescription.
39. The Registrant told the inspectors that once the prescriptions were assembled, he put them into Royal Mail bags and these were picked up by a courier between 13:00 and 14:30 each afternoon. The Registrant thought the courier was AJP but was not sure and that they took the bags to UK Meds in Nottingham. He said UK Meds and EU Meds were the same company and shared the same infrastructure and arrangement with

Royal Mail, so the bags were taken there to reduce the work and time for each pharmacy. The Registrant appeared to be unsure as to what happened if medications were not successfully delivered; he thought EU Meds dealt with that.

40. The inspection report noted that the return address on the printed label was different from the Pharmacy address which meant that the Pharmacy was unable to verify that any returned medicines were securely handled or dealt with safely.
41. The Registrant said that he was personally involved in the process of dispensing, checking and dispatching the medication. He showed the inspectors the 'back end' computer system and said that he was aware that there were other pharmacies dispensing for EU Meds and that when he was dispensing, he was unable to see if a patient had received supplies from these other pharmacies.
42. A random prescription was selected and the information on the system reviewed. This showed the responses to the online questionnaire which were marked as red, amber and green. In respect of this patient, there were two answers highlighted in red including 'do you have capacity to make decisions about your own healthcare'. When asked about this, the Registrant said that he was not concerned by this because the responses are checked by EU Meds before a prescription was issued.
43. The inspector asked whether the Registrant did any patient counselling and he said no, but that the details of the Pharmacy were on the medication label and that he sometimes had received calls from patients.
44. The inspection report noted a large pile of prescriptions, some dating back to 10 July 2021, which had yet to be entered into the private prescription register. Regulation 253 of the Human Medicines Regulations 2012 requires that supplies of prescription

medicines must be recorded either on the day of sale or, if that is not reasonably practicable, the day after.

45. Following on from the inspection, a statutory enforcement notice was applied by the GPhC in that the Pharmacy was issued with a Notice of Conditions by which the Pharmacy was forbidden to sell or supply any medicines against prescriptions issued by third party prescribing services that are not registered with a UK regulator.
46. Further, the inspection report, issued following the conclusion of the inspection, determined that a number of the standards had not been met. The inspection report noted the following failings:
 - The Pharmacy could not demonstrate that it had identified and managed the risks associated with supplying medicines against prescriptions issued to people by an online prescribing service operating outside of UK regulatory control, and which was prescribing medicines which are liable to abuse, misuse and overuse to people, on the basis of an online questionnaire. And it could not show how it adequately safeguarded vulnerable people who may be using this service to obtain medicines which were not clinically appropriate for them and which could lead to patient harm.
 - The Pharmacy had not completed a risk assessment that was sufficiently robust to ensure that the additional risks to people, especially vulnerable patients, that come with a service of this nature were suitably managed. The due diligence checks that had been undertaken by the Pharmacy, such as speaking to the Pharmacy's insurers and asking questions of representatives from EU Meds Ltd., lacked detail and relied primarily on verbal assurances from the company which owned the online prescribing service. The Pharmacy had not been in direct contact with the prescriber, who works within the European Union, to seek personal assurances about their prescribing practices or to corroborate any of the information provided to the Pharmacy by EU Meds Ltd.

- The service had been operational in the Pharmacy since early June 2021 and in that time between 50 and 150 prescriptions had been supplied each day. The overwhelming majority of supplies were for medicines which may be susceptible to abuse, misuse and overuse.
 - The Pharmacy could not demonstrate that the online prescribing service was operating in accordance with relevant UK guidance, including the GPhC Distance Guidance.
 - The Pharmacy did not complete robust clinical checks of prescriptions and the prescribing practices were not audited to ensure that they were safe and appropriate.
 - The Pharmacy did not routinely review prescribing decisions or make clinical interventions and the Pharmacy was not aware of the specific measures that the online prescribing service had in place to help prevent over-ordering given the nature of the medicines being supplied.
 - The Pharmacy had a lack of knowledge of the systems in place for identity checking.
 - The Pharmacy could not show that relevant information or details about prescriptions were routinely shared with the patient's GP to support their ongoing care and make sure their use of medication was being monitored.
47. The Registrant was therefore not carrying out adequate risk assessments, and was reliant upon assurances from EU Meds that the systems and processes were safe. There were no specific risk assessments undertaken by the Registrant in relation to dispensing for EU Meds.
48. The Registrant failed to carry out sufficient governance checks for the arrangement with EU Meds, and failed to take adequate steps to dispense prescriptions safely.

49. EU Meds and the prescriber used by EU Meds were both based outside of the UK and so neither were registered with a UK regulator.
50. The Registrant had very little information about the EU Meds processes, and was unaware of whether consent was obtained to contact GPs, if GPs were contacted or whether information was shared.

28 May 2022

51. On or around 28 May 2022, Person A, had initially tried to order Fluconazole for his wife ('**Patient A**') on pharmacy4U but they needed to speak to Patient A before it could be posted out. Therefore, Person A ordered it through Pharmacy First, and then saw that Fluconazole was on Amazon and ordered it from there instead.
52. The order was placed at 00.29 on 28 May 2022. The dispatch of the medicine was confirmed dated 28 May 2022 timed at 04.23. The medicine was delivered at 8 am on 28 May 2022.
53. The Registrant did not have any information about Patient A, including answers to WWHAM questions, prior to this medication being supplied.

Misconduct and Impairment

54. Misconduct: Having found all of the particulars of allegation proved, the Committee first considered whether the particulars found proved amounted to misconduct and, if so, whether the Registrant's fitness to practise is currently impaired.

55. 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). Paragraph 2.12 reads:

“A pharmacy professional is ‘fit to practise’ when they have the skills, knowledge, character, behaviour and health needed to work as a pharmacist 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.”

56. The Committee heard evidence from the Registrant, and noted the revised Standard Operating Procedures (SOPs) that are now in effect. The Committee noted that these SOPs relate to the “bricks and mortar” side of the business. There were no SOPs relating to the online services as these services had all ceased by 2022. The Committee took into account the submissions made by Mr Corrie and Ms Paterson.
57. Mr Corrie submitted that the Registrant’s conduct was sufficiently serious, and illustrated multiple breaches of GPhC guidance, particularly the Distance Guidance. Patients were put at an unnecessary and unwarranted risk of harm. He submitted that allegations 2-4 relating to the matters involving EU Meds were the most serious, given that high risk medicines were being dispensed without a proper risk assessment. The potential harm to patients, therefore, was significant. The Registrant relied too heavily on assurances made by EU Meds, and did not check whether they or the prescriber were subject to UK regulatory oversight. In so doing, he disregarded the Distance Guidance, and his duties as a RP, SI and Pharmacy Owner. This created an unacceptable risk of harm.

58. Mr Corrie further submitted, in relation to allegations 1 and 5, that the standards for supplying P-Meds were high, requiring checks that any supply was safe. The Registrant did not have any processes in place for obtaining any information, let alone WWHAM information, and again, this amounted to a serious breach of the standards of the profession. The provision of medicine packet information on Amazon and eBay was simply insufficient. This is also aggravated, he submitted, by the fact that the Registrant had already been subject to notice concerning online services with regards to the EU Meds allegations.
59. Mr Corrie further submitted that this misconduct amounted to current impairment of the Registrant's fitness to practice. Whilst there has been no repetition since, the Pharmacy has been subject to enforcement conditions. He submitted that insight was limited, with the Registrant saying that he ignored these obvious risks purely due to naivety. There remains a concern with repetition, The SOPs that were produced reinforced the need, even within a "bricks and mortar" practice, that information needs to be obtained about patients before medicines are dispensed. Mr Corrie emphasised the wider public interest, and the need for the Committee to declare and uphold professional standards. He stressed the case of *Fopma v GMC* [2018] EWHC 714 (Admin), which held that *"a failure to find impairment in any given case, whilst warnings as to future conduct can still be issued, is tantamount to an indication on behalf of the profession that conduct of the kind need not have regulatory consequences"*.
60. Ms Paterson made submissions on behalf of the Registrant. She submitted that whilst it may be that his conduct amounts to misconduct, his current fitness to practice is not impaired. She emphasised that any breach of professional standards must be serious, indeed, deplorable. She urged the Committee to consider every allegation separately, and to consider whether they reach the appropriate threshold.
61. Ms Paterson submitted that the Registrant acknowledges his fault and has taken full accountability of this. He did provide some safeguards, such as providing all medicine package information on the website, as well as his contact details. She submitted that

this is a Registrant who did not have complete disregard for his duties regarding patient safety. She stressed that the Registrant has taken full responsibility for his need to keep up to date with the guidance. The Registrant acted in good faith in relying on EU Meds' assurances, and taking their representations at face value.

62. Ms Paterson emphasised that the conduct can, and has been, addressed. The Registrant has demonstrated considerable insight and affected remediation. He has expressed remorse, and understands the risks associated with his conduct. She emphasised that the Registrant now fully appreciates the relevant guidance, and that there have been no concerns raised in the 4 years since the incidents. Ultimately, this was conduct in a single year of an otherwise unblemished 20 year career. She stressed that the public interest would require assessing what an informed and reasonable member of the public would think about this conduct.

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

Decision on misconduct

64. When considering whether the particulars found proved amounted to misconduct the Committee took into account the *Good decision making: Fitness to practise hearings and outcomes guidance*.

65. The Committee considered whether the Registrant had breached any of the Standards for Pharmacy Professionals, Standards for Pharmacies and the Distance Guidance. The Committee determined that there had been a number of breaches of the Standards, specifically:

- **Distance Guidance 1.1 (Risk Assessment), paragraph 1:** *"make sure you gather evidence about the risks for each individual service, medicine and medical device*

that you provide at a distance, including on the internet, before you start providing the service”

The Committee considered that no evidence was properly gathered about the risks of the eBay, Amazon or EU Meds services, especially not before the Registrant had started providing the service.

- **Distance Guidance 1.1 (Risk Assessment), paragraph 2:** *“risk assessment includes considering:*
 - i. the risks you have identified and how these will be managed*
 - ...*
 - ii. how medicines are supplied, including counselling and delivery*
 - ...*
 - iii. what records you will keep, depending on the nature of the pharmacy services you provide*
 - ...*
 - iv. changes in the number or scale of services”*

The Committee considered that the online services risk assessment was inadequate, and failed to properly consider delivery, supply, record keeping and the effect of the change of scale on the business.

- **Distance Guidance 1.1 (Risk Assessment), paragraph 5:** *“if parts of your pharmacy service are the responsibility of several different pharmacies and staff – or the responsibility of a third party, agent or contractor – you have considered how the systems you use to provide your pharmacy service work together.”*

The Committee noted that there was inadequate consideration of the role of EU Meds as a third party, and how systems, including regulatory systems, would work together.

- **Distance Guidance 1.1 (Risk Assessment), paragraph 6:** *“We expect you to make sure you do not work with online providers who are trying to circumvent the regulatory oversight put in place within the UK to ensure patient safety throughout the healthcare system. Working with prescribers who are not appropriately registered with the relevant UK professional regulator, and with prescribing services not based in the UK, could create significant extra risks for patients and the public. If your service lawfully involves working with prescribers or prescribing services operating outside the UK, you should make sure that:*
 - i. You successfully manage the extra risks that this may create*
 - ...*
 - ii. The prescriber is registered in their home country where the prescription is issued and can lawfully issue prescriptions online to people in the UK*
 - iii. The prescriber is working within national prescribing guidelines for the UK”*

The Committee deemed that there was insufficient consideration by the Registrant of regulatory oversight in relation to the EU Meds service. No additional checks were undertaken by the Registrant. Instead the Registrant placed passive reliance on EU Meds’ own representations.

- **Standards for Pharmacy Professionals 1 - Pharmacy professionals must provide person-centred care:**
 - i. Listen to the person and understand their needs and what matters to them*
 - ii. Give the person all relevant information in a way they can understand, so they can make informed decisions and choices*

iii. make the best use of the resources available

The Committee was of the opinion that the online services provided by the Registrant were not person-centred. The Registrant was unable to ascertain whether medicine which he supplied was appropriate and proportionate in dose and the Registrant did not intervene effectively. The patient was not provided with appropriate advice as to side effects. Red flags were improperly disregarded.

- **Standards for Pharmacy Professionals 2 - Pharmacy professionals must work in partnership with others**

- i. Take action to safeguard people, particularly children and vulnerable adults*
- ii. Demonstrate effective team working*
- iii. Contact, involve and work with the relevant local and national organisations*

The Committee considered that the safeguarding of patients, particularly children and vulnerable adults was not properly considered, especially with regards to the supplying of P-Meds. There was insufficient teamworking between the Registrant, EU Meds and their prescriber to ensure that the care of patients was a first priority. The Registrant failed to contact and engage with the GPhC, or to consider at all its Distance Guidance which related to exactly the service that he was providing.

- **Standards for Pharmacy Professionals 3 - Pharmacy professionals must communicate effectively**

- i. Check the person has understood the information they have been given*
- ii. Overcome barriers to communication*
- iii. Communicate effectively with others involved in the care of the person*

By requiring a patient to contact him, the Registrant had effectively reversed the burden on a pharmacist communicating with a patient. Better checks were

needed. The Registrant neglected to conduct further checks, regarding the prescriber, which he explained as being due to the website being in German. He failed to translate key documents or make contact with appropriate organisations to ensure regulatory compliance. The Registrant did not contact the prescriber directly to discuss patient care.

- **Standards for Pharmacy Professionals 5 - Pharmacy professionals must use their professional judgement**

- i. Make the care of the person their first concern and act in their best interests*
- ii. Use their judgement to make clinical and professional decisions with the person or others*
- iii. Have the information they need to provide appropriate care*
- iv. Recognise the limits of their competence*

The Committee considered that there was insufficient professional curiosity and exercise of professional judgement in making clinical and professional decisions, especially regarding online services. The Registrant failed to recognise his lack of competence in running an e-business, and this then affected his exercise of judgement at the clinical level.

- **Standards for Pharmacy Professionals 6 - Pharmacy professionals must behave in a professional manner**

- i. "People expect pharmacy professionals to behave professionally. This is essential to maintaining trust and confidence in pharmacy."*
- ii. Maintain appropriate personal and professional boundaries with the people they provide care to and with others*

The Committee noted that the Pharmacy had enforcement conditions placed on it after the GPhC inspection of 30 July 2021. Whilst the conditions did not forbid the Pharmacy from online services, it did clearly state in the final summary:

“An inspection of the registered pharmacy on 26 July 2021 has found system wide failures in the operation of the pharmacy which presents a serious risk to patient safety. The risks are heightened by the nature of the services provided including the online supply of high-risk medicines liable to abuse, misuse and overuse with inadequate risk management and safeguarding in place.”

The Committee considered that the Registrant had been placed on notice by the GPhC due to the risks to patient safety because his practice. In light of this, the Committee found it concerning that the Registrant had conducted himself 10 months later as outlined in the particulars at allegation 5.

The public would expect an experienced professional pharmacist to heed warnings as to online sales and cease or make changes to such services if necessary. The organisation and appropriate recording of dispensed private prescriptions, the lack of risk assessments, not following guidance, and selling on eBay and Amazon without proper checks were not indicative of professional behaviour.

- **Standards for Pharmacy Professionals 9 - Pharmacy professionals must demonstrate leadership**
 - i. take responsibility for their practice and demonstrate leadership to the people they work with*
 - ii. assess the risks in the care they provide and do everything they can to keep these risks as low as possible*
 - iii. lead by example, in particular to those who are working towards registration as a pharmacy professional*

The Committee considered that there were insufficient risk assessments to demonstrate leadership to the rest of the Registrant’s pharmacy staff. The Registrant as Director and SI, failed to lead by example in following guidance and adhering to the required standards of a pharmacy professional.

- **Standards for Pharmacies 1 - The governance arrangements safeguard the health, safety and wellbeing of patients and the public**

The Committee considered that the Registrant failed to implement effective governance mechanisms. This was particularly in relation to standards of health, safety and wellbeing of patients and the public.

- **Standards for Pharmacies 4 - The way in which pharmacy services, including the management of medicines and medical devices, are delivered safeguards the health, safety and wellbeing of patients and the public**

The Committee considered that management was inadequate to provide sufficient safeguards for patients and the public.

66. 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).
67. Accordingly, the Committee concluded that, in its judgement, the ground of misconduct was established. The Committee considered each of the sub allegations separately and concluded that the Registrant's behaviour fell far short of what would be proper in the circumstances. There were multiple and serious breaches of many of the standards, which had occurred over a period of just over a year, involving supplying significant volumes of medicines, without the necessary risk assessments, governance structures or oversight. Some of the medications supplied were high risk medications liable to abuse, misuse or overuse, which had the potential to cause serious harm to patients. Such breaches fell far below the standards expected of a pharmacist.
68. The Committee therefore went on to consider whether the Registrant's fitness to practise is currently impaired.

Decision on Impairment

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

A. present an actual or potential risk to patients or to the public?

The Committee was of the view that there is an actual risk to patients and the public.

B. has brought, or might bring, the profession of pharmacy into disrepute?

The Committee considered that the actions and omissions of the Registrant have brought the profession of pharmacy into disrepute.

C. has breached one of the fundamental principles of the profession of pharmacy?

The Committee considered that fundamental principles of the profession of pharmacy have been brought into disrepute by the Registrant carrying out a service in a cavalier manner, without proper knowledge, governance and insight. The Registrant was insufficiently proactive to find out the standards that he needed to follow when he started this new service in his business.

D. means that the integrity of the registrant can no longer be relied upon?

The Committee did not consider that the integrity of the Registrant was in question.

70. The Committee then went onto consider whether the Registrant's actions were remediable, and considered that they were indeed remediable. The Registrant has, to a large degree, accepted responsibility by making full admissions.

71. The Committee then considered whether the misconduct has been remedied. In analysing this, the Committee considered the new SOPs, (which only related to the bricks and mortar aspects of his business), and noted that the Registrant had explained that he no longer undertakes any online services and therefore does not have any SOPs relating to this. The Committee also noted the materials and evidence put forward by the Registrant regarding his insight. The Committee noted the Registrant's apology, remorse, reflections, his lack of previous regulatory concerns, his CPD record, his full cooperation with the investigation and the regulatory process, and the changes he has made to his practice, including training staff members and colleagues to adopt a more risk-averse approach within the last 4 years. It also noted the positive testimonials from colleagues and those who have known him for many years. It also acknowledged that no further issues have come to light since the matters outlined in these allegations.
72. The Committee was of the view that the Registrant has demonstrated some insight and has implemented some measures to ensure that the misconduct does not happen again. The Registrant explained that he has a much more risk averse filter which he applies to all of his business, is open with colleagues and peers about his practice and has put in place much more rigorous procedures to ensure that such failings will not occur again. He has also stopped all online sales and told the Committee that he has no intention to provide such services again in the future.
73. However, despite such measures, the Committee determined that the Registrant's insight is currently not sufficiently developed. The Registrant was not able to explain in sufficient detail his understanding of the triggers for his behaviour, and why, given his significant experience, he had acted in the way that he did with a disregard for safety of patients and turning a blind eye to the governance and safety aspects of his work.

74. Furthermore, the Committee noted that he had minimised the potential impact of his actions by saying that no harm had been caused to patients. The Committee had no evidence of this and determined that the potential for actual harm was significant considering the nature and volume of medicines involved. Given that the Registrant has 20 years of experience as a pharmacist, the Committee did not consider the Registrant's assertion that he had started this new business and fallen short of so many standards as a result of his naivety to be a sufficiently detailed explanation for why the Registrant had engaged in this misconduct.
75. Importantly, the Committee considered that this explanation did not provide sufficient guarantees for such behaviour not to occur again in future, especially given the changing nature of pharmacy. Simply stopping online services is an insufficient action to demonstrate that he has gained insight into the triggers for why he had allowed himself to engage in supplying and dispensing medication without any consideration as to the risks to patient safety and proper oversight and governance. The Registrant explained that he now takes a more risk-averse approach and despite being offered the possibility of taking on new services, such as supplying weight loss medication, he has refused such offers as he did not consider the risks to be worthwhile, even though it might be financially beneficial. He restricts himself to the "bricks and mortar" aspects of pharmacy. However, he has not provided sufficiently detailed reflection on what he would do differently in the future if faced with a situation whereby he needs to start providing a new service with which he was unfamiliar.
76. The Registrant has also not shown in sufficient detail how he has fully embedded into his current practice the learning he has undertaken into the concerns raised. The Committee was sympathetic to the life pressures which the Registrant was dealing with in 2021 but was concerned by the Registrant attempting to expand his business while under such pressures and did not hear any explanation as to how the Registrant would manage things differently should such pressures reoccur in the future.

77. The Committee noted that, even though this may not have been the primary motivation of the Registrant, the financial benefit from the Registrant's actions was substantial.
78. Therefore, the Committee was not satisfied that the misconduct was highly unlikely to be repeated, and determined that further insight was required to mitigate this risk. Importantly, the Committee was of the view that there is a high risk of actual harm to others from any repeated misconduct, given the serious nature of the Registrant's actions and omissions. The consequences of the Registrant's actions have already led to medicines being supplied without full clinical oversight.
79. Accordingly, given the concerns about the risk of actual harm to patients and the public, the Committee found that the Registrant's fitness to practice is currently impaired on public protection grounds.
80. The Committee also considered whether the Registrant's fitness to practice was impaired on public interest grounds. It concluded that the wider public interest requires a finding of impairment due to the serious nature of the conduct found proved and the need to maintain confidence in the profession and regulator. This will make it clear to other professionals what standards are expected.
81. The Committee therefore found the Registrant's fitness to practise to be currently impaired on both public protection and public interest grounds.
82. The Committee then went on to consider the issue of outcome.

Decision on Outcome

83. 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 Order. The Committee should consider the available outcomes in ascending order from least restrictive, take no action, to most restrictive, removal from the Register, in order to identify the appropriate and proportionate outcome that meets the circumstances of the case.
84. The purpose of an outcome is not to be punitive, although 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 professional standards. The Committee is therefore entitled to give greater weight to the public interest over the Registrant's interests.
85. The Committee had regard to the Council's '*Good decision making: Fitness to practise hearings and outcomes guidance*' to inform its decision.
86. The Committee took into account the submissions made by Mr Corrie and Ms Paterson. It also noted the offer from Farhan Ali to be the Registrant's mentor and from Ateeq ul Rehman to be SI Pharmacist, as well as the eBay profits document provided to the Committee before the submissions on outcome.
87. The Committee accepted the advice of the Legal Adviser.
88. The Committee first considered what, if any, aggravating and mitigating factors there may be.
89. The Committee identified the following aggravating factors:

- a. The Registrant being on notice as to regulatory concerns in the context of particular 5;
- b. There being multiple breaches across three separate services;
- c. The Registrant's financial gain from the conduct;
- d. The Registrant's lack of awareness of the GPhC distance guidance;
- e. The Registrant's 20 years' experience as a pharmacist, as he should have been aware of regulatory risks; and
- f. The risk to patients, especially with regards to dispensing high-risk medications from prescriptions provided by EU Meds and the nature and high volumes of medications supplied through the online platforms without having the necessary governance in place.

90. The Committee identified the following mitigating features:

- a. There is evidence of developing insight;
- b. The absence of any previous regulatory concerns regarding the Registrant;
- c. The Registrant's personal circumstances at the time of the conduct;
- d. The Registrant's bricks and mortar pharmacy having been compliant; and
- e. The Registrant's full admissions to the allegations and cooperation in the investigative and regulatory process.

91. The Committee could not agree with Ms Paterson's submission that this was conduct over a course of 4 months and remained of the view that the conduct took place over the course of just over a year. The Committee nonetheless noted that the Registrant had compliantly practised for the other 19 years of his pharmacy career.

92. The Committee went on to consider the potential outcomes in ascending order of seriousness.
93. To take no action. The Committee considered that taking no action was not appropriate as the Registrant's misconduct created a risk to the public. Remedial action is necessary to maintain public confidence in the profession. The public would rightly expect the Registrant to remediate his practice in light of his actions.
94. Advice. As impairment is found, the Committee considered that Advice is not an appropriate outcome.
95. Warning. The Committee was not satisfied that a warning would safeguard against the risk to the public or uphold the public interest as there was proven misconduct coupled with incomplete insight and partial remediation. A warning would not provide any restriction to the Registrant's practice where the level of potential harm was high, and the Registrant had been put on notice regarding regulatory concerns.
96. Conditions of Practice. The Committee next considered the imposition of conditions of Practice. A Conditions of Practice Order would allow the Registrant to practise albeit with restrictions. The Committee must determine whether a conditions of practice Order would be appropriate given the concerns identified regarding the Registrant's practice, in particular whether conditions would protect the public from harm, be sufficient to mark the seriousness of the matter so as to maintain public confidence in the profession and the regulator, and whether it would be sufficient to uphold standards within the profession.
97. The Committee, over an extended period of time, gave careful consideration to the appropriateness of a Conditions of Practice Order. The Committee carefully considered

the conditions proposed by Ms Paterson, including whether it could impose a condition (i) to prevent the Registrant from carrying out pharmacy services online, (ii) to prevent the Registrant from acting as a SI, and (iii) to require the appointment of a mentor, and (iv) to require the Registrant to produce reflective pieces. After extensive deliberation, the Committee concluded that a Conditions of Practice Order would not sufficiently uphold the public interest. A well-informed member of the public would expect that, before being allowed to continue to practise, a registrant who had engaged in this misconduct would be required to satisfy the GPhC that they had developed sufficient insight into the core reasons as to why they had engaged in this misconduct and to explain fully what they would do differently going forward. The Registrant in this case has not done that in a sufficiently robust way.

98. The Committee was also concerned as to the workability of any conditions given that the Registrant is a director of the Pharmacy. The Committee was aware that conditions must be clear, workable and enforceable. The Committee was of the view that the risk presented by the Registrant is not limited solely to the provision of online services. It concerns the Registrant's lack of proper explanation as to why he had ignored safe practice, regulatory guidance and good governance when he started providing the new online services. The risk therefore extends to any new services with which the Registrant may decide to offer from the Pharmacy in the future. The burden is on the Registrant to explain to a future Committee that his understanding of the proper governance and regulatory processes required to provide a safe service to the public, has sufficiently developed. The Committee decided that conditions could not be formulated to address this risk.
99. As such, the Committee was not satisfied that a Conditions of Practice Order was suitable in this case.
100. Suspension Order. The Committee next considered whether suspension would be a proportionate outcome. The Committee noted the Council's guidance which indicates that suspension may be appropriate where:

“The committee considers that a warning or conditions are 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”

101. The Committee considered that it was necessary to highlight to the public, and the wider profession, that the Registrant’s conduct was unacceptable. It considered that public confidence demanded no lesser outcome in this instance. The Registrant engaged in high-risk conduct, especially in relation to supplying medication that was liable to misuse, overuse and abuse.
102. Issues with the Registrant’s insight remain. The Committee was particularly concerned with the Registrant’s explanation for his behaviour being one of naivety, as well as his lack of awareness of GPhC guidance, and the Registrant’s attitude in assuming that safety checks had been made by EU Meds when risks were flagged to him by the inspector. The Committee was of the view that some of his conduct was reckless. The Committee recognised that a suspension order would impact the Registrant detrimentally both reputationally and financially, but concluded that the need to protect the public and the public interest outweighed the Registrant’s interest in this case. The Committee considered that a short period of suspension would give the Registrant sufficient time to reflect, and further develop his insight before being allowed to continue to practise. The Committee was satisfied that this is a proportionate outcome.
103. The Committee considered the length of time for the Suspension Order. It considered that a 3-month period would be sufficient to give the Registrant time to reflect in

detail, to be able to satisfy a review Committee that he has developed insight and is fit to practise once more. The Committee recognises that there is a balance to be struck between the safeguarding the public interest and the Registrant's interest to keep practising, and was satisfied that a short suspension would be the least restrictive outcome to put on to the Registrant's practice, whilst also sending a message to the profession and the public that such conduct was unacceptable. It would also uphold public confidence in the profession.

104. To this end, the Committee decided that the Registrant should be suspended from practice for 3 months to give him time to create a detailed reflection and develop insight and to return to the proper standard expected of him. A future Committee would be assisted by a reflective piece addressing the following concerns:

- Why he started providing a new service without making the necessary and appropriate checks;
- Why he made assumptions with regards to EU Meds;
- Why he ignored red flags that had been raised;
- Reflecting on the wider impact of his misconduct, including patient safety and the lack of proper controls and on not only what did actually happen, but also the potential for what could have happened;
- Reflecting on his approach to providing new services in the future;
- Explaining how guidance, learning and CPD have been embedded into his practice, rather than just noting that guidance has been read.

105. Removal. The Committee considered removal from the register, however was of the view that the Registrant's behaviour was not fundamentally incompatible with being a registered professional, so removal is not appropriate in this case. The Registrant has fully engaged, has developed some insight, and has undertaken some remediation. Given that there have been no concerns raised before these incidents or subsequently,

and the positive testimonials provided, the Committee decided that removal would be a disproportionate outcome.

106. **The Committee therefore directs that the entry in the Register of the Registrant concerned be suspended, for a period of 3 months.**

Decision on Interim Measures

107. The Committee invited submissions on any interim measures in light of the findings above. Mr Corrie requested an interim suspension on the grounds that it was necessary for public protection and the public interest. Ms Paterson submitted that an interim suspension was not necessary or proportionate.
108. The Committee considered whether it was necessary to impose an interim measure of suspension 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. The Committee considered whether such an interim measure would be consistent with the Committee's determination with regards to the substantive order.
109. The Committee took account of the fact that its decision to suspend the Registrant from the Council register would not take effect until 28 days after the Registrant was formally notified of the outcome, or until an appeal was concluded.
110. The Committee was satisfied that it was necessary for an interim suspension to be in place prior to the substantive order taking effect. The Committee was satisfied that such a measure is necessary on the grounds of public protection and the public interest. Whilst the Committee acknowledged that there would be an immediate

effect on the Registrant's pharmacy, it took into account the evidence of the two colleagues willing to take over as SI.

111. Allowing the Registrant to practise in the period before the substantive order comes into place would create a risk to the public, as the Committee has found that the Registrant currently has a lack of sufficient insight into his misconduct and the reasons underlying it. As such, it is necessary to impose an interim measure on public protection grounds. The Committee was also satisfied that it is necessary in the public interest for such a measure to be made. The Committee was mindful of the need for any such measure to be proportionate, and was satisfied that the imposition of an Interim Suspension measure would be proportionate and necessary.
112. The Committee therefore ordered that the entry of the Registrant in the register be suspended forthwith, to last until the coming into force of the substantive order, or for 18 months (whichever time period is sooner).
113. This concludes the determination.