General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote videolink hearing

12 February 2026 – 16 February 2026

Registrant name:	Mr Mohammed Yasir
Registration number:	2056174
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Mr Vishal Misra (Chair) Dr Gazala Akram (Registrant member) Ms Stephanie Hayle (Lay member)
Committee Secretary:	Mr Adam Hern
Registrant:	Present and not represented
General Pharmaceutical Council:	Represented by Mr Jim Olphert, Case Presenter
Facts proved by admission:	1, 2 (2.1-2.7), 3 (3.1-3.10), 4 (4.1-4.7), 5 (5.1-5.5) and 6 (6.1 and 6.2).
Facts not proved:	None
Fitness to practise:	Impaired
Outcome:	12-month suspension with review
Interim measures:	Interim Suspension

This 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 16 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

You, a registered pharmacist/pharmacy technician

1. *Between 2 January 2020 and 31 December 2021, prescribed and/or approved the prescriptions set out in Schedule A for medicines requiring ongoing monitoring and/or medicines unsuitable to be prescribed on the basis of an online questionnaire-based consultation.* – Admitted

2. *In relation to 1 above, you did not prescribe medicines in accordance with and/or pay due regard to the relevant guidance on prescribing from the General Medical Council ('GMC'), the Royal Pharmaceutical Society ('RPS') and/or the General Pharmaceutical Council ('GPhC') in that you prescribed in circumstances where you:*

    2.1. *did not obtain adequate information in relation to the patients' health in advance of prescribing* – Admitted;

    2.2. *relied principally on the information received in an online questionnaire* – Admitted;

    2.3. *did not access and/or attempt to access patients' Summary Care Record ('SCR'), General Practitioner ('GP') medical records and/or specialist clinic records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history* – Admitted;

    2.4. *did not request a face-to-face or remote consultation with patients in order to adequately examine the clinical need for medication* – Admitted;

    2.5. *did not adequately consider the possibility of medication dependence and misuse* – Admitted;

    2.6. *did not refer patients back to their GP for appropriate assessment and/or review and/or monitoring* – Admitted*, and/or;*

    2.7. *did not put adequate safety-netting in place* – Admitted.

3. *Between approximately 14 February 2021 and 14 July 2021 did not ensure that the Pharmacy's prescribing model or service supported safe prescribing and/or dispensing of medications in that:*

    3.1. *no face-to-face or remote consultation took place* – Admitted;

    3.2. *patients provided information primarily through a questionnaire* – Admitted;

3.3. *the questionnaire at 3.2 above could be easily manipulated by patients as it notified them of answers which could prevent the supply of the medication they desired and permit the patient to change their answer* – Admitted;

3.4. *the identification of repeat or early ordering was reliant upon manual checks being made by team members* – Admitted;

3.5. *no audits were completed to assess the safety and quality of the prescribing service* – Admitted;

3.6. *no risk assessments had been conducted in respect of supplying medicines to people who may be vulnerable* – Admitted;

3.7. *inadequate ID checks were in place which created a risk of patients using another person's ID to make a purchase* – Admitted;

3.8. *medicines were supplied outside the limits set by the pharmacy's medication guidelines document* – Admitted;

3.9. *patients who had previously been prescribed and supplied a medicine through the pharmacy were not required to complete a fresh questionnaire for repeat orders until 12 months had elapsed* – Admitted;

3.10. *no records were kept of prescribing decisions made and/or information obtained from the patient's SCR* – Admitted.

4. *Between approximately 14 July 2021 and 3 October 2022 did not ensure that the Pharmacy's prescribing model or service was capable of supporting safe prescribing and/or dispensing of medications in that:*

4.1. *no face-to-face or remote consultation took place* – Admitted;

4.2. *patients provided information primarily through a questionnaire* – Admitted;

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

4.4. *the identification of repeat or early ordering was reliant upon manual checks being made by team members* – Admitted;

4.5. *there were insufficient mechanisms in place to monitor the prescribers' compliance with prescribing guidelines* – Admitted;

4.6. *medicines were supplied outside the limits set by the pharmacy's medication guidelines document where:*

4.6.1. *reasons for the supplies in 4.5 above outside the limits were not recorded* – Admitted;

4.6.2. *the supplies in 4.5 above outside the limits were not identified in the audits conducted* – Admitted;

4.7. *checks were not made on ordering history or consultation questionnaires during the dispensing process* – Admitted.

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

5.1. *read, consider and assimilate the completed questionnaire* – Admitted;

5.2. *consider if it was clinically necessary to check with the patients' GP and/or contact the GP* – Admitted;

5.3. *consider if it was clinically necessary to contact the patient and/or conduct a face-to-face consultation with the patient* – Admitted;

5.4. *consider if it was necessary to check the clinical background of the patient and/or check the clinical background* – Admitted;

5.5. *consider the steps you ought to take to prescribe in accordance with UK prescribing guidance as set out at 2 above* – Admitted.

6. *On 2 March 2021, 21 April 2021 and 19 May 2021 you prescribed Propranolol 40mg to Patient A in circumstances where you:*

6.1. *knew or ought to have known, that the patient had already obtained repeated orders of the medicine from the Pharmacy, and you did not adequately consider the possibility of dependence or misuse* – Admitted;

6.2. *did not notify the patients' GP or other healthcare professional or designated safeguarding lead of the repeated requests for the medicine to prevent harm* – Admitted.

Documentation

Document 1 - Council's hearing bundle

Document 2 - Council's skeleton argument

Document 3 – Council's evidence matrix

Document 4 – Combined prescription data

Document 5 - Registrant's bundle

Document 6 – Registrant's skeleton argument

Document 7 – Registrant's statement

Document 8 – Registrant's bundle

Document 9 – GPhC inspection report

Witnesses

No live witnesses were called by either the Council or the 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:

   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 6 January 2026 from the Council headed 'Notice of Hearing' addressed to the Registrant and sent to their registered email address as noted on the Register.

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.

Registrant's response to Particulars of allegation

8. The Registrant admitted particulars 1-6 in their entirety.

9. In the light of the above, and by the application of Rule 31(6) of the Rules, the admitted factual particulars were found proved.

10. The Committee went on to

    - consider whether the Registrant's fitness to practise is currently impaired which is a matter for the Committee's judgement.

Background

11. The Registrant was, at all material times, the Superintendent Pharmacist ('SI') and owner of My Pharmacy – an online pharmacy based at the time of the allegations at 58A Queen Street, Blackburn, BB6 7AL ('the Pharmacy').

12. The Registrant was a Pharmacist Independent Prescriber ('PIP') and was initially the only PIP at the Pharmacy. The Pharmacy's main service was the online prescribing service which uses an online questionnaire model. People were required to complete the questionnaire which is designed to assess suitability for the prescriber to prescribe the requested medicine. The allegations concern private prescriptions made through this online service. No concerns were raised regarding the supply of medicines against an NHS prescription.

13. The Pharmacy came to the attention of the Council as a result of an email sent by a pharmacist, Nisa Gurung, working at St Peter's Hospital, Chertsey. The Pharmacist who raised the issue noted that a patient at the hospital had identified that she had been able to purchase propranolol from the Pharmacy under her mother's name. The pharmacist noted that "*I did have a quick look on to their website and it does let you buy [prescription only medication] online. For the order, buyer has to answer few*

preset questions as a free consultation, then it leads straight to check out. It seems like there is no actual online consultation by the prescriber and system put in place to verify the patients' ID."

14. As a result, an unannounced inspection of the Pharmacy was undertaken on 14 June 2021. This was about 5 days before the events that would lead to the tragic death of Patient A. The inspection was undertaken by Faiyaz Haque, who led the investigation, Neha Raimaya, a Senior Clinical Pharmacy Advisor and Specialist Inspector for the Council and Lisa McCreesh, who was then a Deputy Regional Manager for the Council.

15. The final inspection report noted that the Pharmacy did not meet all the Council's standards, highlighting failings of Standard 1 (Governance) and Standard 4 (Services). An action plan was created to address the failings identified.

16. The Registrant and the Pharmacy worked with the Council on the action plan which followed the inspection. However, following a further inspection on 31 October 2022 (after the Pharmacy had moved to 1A Hesketh Street, Blackburn BB6 7DW), the inspectors again concluded that the standard were not all met, particularly in respect of the risks regarding online prescribing.

17. Between 2 January 2020 and 31 December 2021, the Registrant prescribed and/or approved the prescriptions for medicines requiring ongoing monitoring and/or medicines unsuitable to be prescribed using an online questionnaire based consultation, namely:

    a. Propranolol (3,699 prescriptions),
    b. Orlistat (1,101 prescriptions),
    c. Ventolin/Salbutamol/Salamol (12,659 prescriptions),
    d. Finasteride (250 prescriptions); and
    e. Sildenafil (974 prescriptions).

18. In prescribing the above medications, the Registrant failed to pay due regard to guidance from the GMC, the RPS and the Council. The Committee has seen the Council's inspection report mentioned at paragraph 15, above. Multiple failures were noted to paying due regard to the GMC's *Good practice in prescribing and managing*

medicines and devices (2013) guidance, the RPS' *A Competency Framework for all Prescribers (2016)* and *(2021*) guidance, the Council's *Guidance for registered pharmacies providing pharmacy services at a distance including on the internet (2019)* and *Guidance for pharmacist prescribers (2019)*.

19. Faiyaz Haque's witness statement described the Pharmacy as "*an online pharmacy that is closed to the public*." The prescribing process required patients to complete an online questionnaire. This was then reviewed by the Registrant, who would then issue a private prescription for dispensing in the Pharmacy.

20. This process was manipulable by patients. If patients answered questions in a manner that rendered them unsuitable for being prescribed them, then patients would be notified and told to contact their GP. However, patients could change the answers in order to be deemed suitable for the medications. The Pharmacy had no oversight of these changes.

21. Once patients had been prescribed medication through the Pharmacy's system they did not need to complete the questionnaire again. The answers provided to the initial questionnaire were not made available for the Registrant to consider. The Registrant confirmed to the Council's inspection team that patients would be required to complete fresh questionnaires for repeat orders only once 12 months had elapsed.

22. The Pharmacy had no 'safety-netting' in place, in that the Registrant failed to communicate with GPs, healthcare professionals or safeguarding leads. The Pharmacy did not maintain stringent checks on repeat prescriptions or early prescription requests. There was a failure to check and/or maintain patient medical records within the Pharmacy or follow up and/or communicate with patients.

23. The Inspection Report summarised the Pharmacy's adherence to Standard 4 (Services) as:

> *"The pharmacy doesn't have enough safeguards in place to ensure it manages all its services safely. It doesn't always make sure that people using the online prescribing service have the ongoing checks they need. And it doesn't always share relevant information with other healthcare providers. The pharmacy doesn't have robust processes to make sure its team members always provide safe dispensing services. The pharmacy obtains its medicines from appropriate sources. And the team carries out regular checks on its medicines to make sure they are fit for purpose*."

24. The Inspection Report summarised the Pharmacy's adherence to Standard 1 (Governance) as:

> "*The pharmacy doesn't identify and manage all the risks with the services it provides, including when making changes to its services. And it doesn't always implement the necessary changes to manage risks, especially for its online prescribing service. The pharmacy keeps most of the records required by law. But it can't show its records for its private prescription as it needs to do. And it doesn't keep any records of clinical decisions it makes as a part of its prescribing service. Pharmacy team members know their role in helping protect vulnerable people. But the pharmacy doesn't take sufficient care to identify vulnerable people accessing its online prescribing service. Team members keep people's private information secure. And they respond suitably when they make mistakes to help prevent the same mistakes happening again.*"

25. Due to the nature of the Pharmacy as online only, there was a failure to make any face-to-face or remote consultations for patients with prescribers. It was also noted that the Registrant prescribed medication, such as Propranolol, with such frequency that it could not be possible for the Registrant to have read, considered and assimilated the questionnaire before issuing the prescription.

26. The Pharmacy's process for checking repeat and/or early orders was reliant on a system of manual checks being made by team members. The Pharmacy did not have updated risk assessments to monitor their predominantly online model. Thus, there were insufficient mechanisms in place to monitor compliance with prescribing guidelines.

27. The failure to properly update risk assessments to reflect the online nature of their model, meant that the Pharmacy supplied medicine outside the limits of its own medication guidelines. There was neither a documented reason for these instances nor were they identified within the Pharmacy's audit process.

28. The above culminated in Patient A's tragic death. Patient A died from a fatal overdose of Propranolol. Between 2 March 2021 and 16 June 2021, Patient A made seven

orders for Propranolol through the Pharmacy. It was noted that on 15 June 2021, the Pharmacy sent an email to Patient A refunding a single order of Propranolol.

29. The Pharmacy knew, or ought to have known, the full ordering history of Patient A. As such, the Pharmacy failed to properly consider the possibility of any dependence or misuse of the medicine by Patient A. Further, the Pharmacy failed to notify Patient A's GP, any other healthcare professional or safeguarding lead as to the risks of harm.

Decision on Facts

30. When considering each particular of allegation, the Committee bore in mind that the burden of proof rests on the Council and that particulars are found proved based on the balance of probabilities. This means that particulars will be proved if the Committee is satisfied that what is alleged is more likely than not to have happened.

31. The Committee noted that the Registrant had admitted all the particulars. Therefore, pursuant to Rule 31(6), the facts of all the allegations were found proved.

Misconduct and Impairment

32. Having found all of the particulars of allegation proved, the Committee went on to consider whether the particulars found proved amounted to misconduct and, if so, whether the Registrant's fitness to practise is currently impaired.

33. The Committee took into account the submissions made by Mr Olphert and the Registrant.

34. Mr Olphert submitted that misconduct is a question of judgement. Misconduct was a word of general effect which involved some act or omission that falls short of the relevant standards of propriety. The requirement for misconduct to be "*seriously reprehensible*" (*Khan v Bar Standards Board* [2018] EWHC 2184 (Admin)) was brought to the Committee's attention.

35. Mr Olphert also directed the Committee's attention to *Remedy UK Ltd v General Medical Council* [2010] EWHC 1245 (Admin) which outlined that misconduct may "*involved sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise*."

36. Mr Olphert submitted that the Registrant's misconduct spoke directly to his fitness to practise pursuant to Rule 5(2). He submitted that the Registrant was impaired in that he:

a. presents an actual or potential risk to patients or to the public,
b. has brought, or might bring, the profession of pharmacy into disrepute; and
c. has breached one or more of the fundamental principles of the profession of pharmacy.

37. The Committee was directed to the guidance on impairment from *Cohen v General Medical Council* [2008] EWHC 581 that requires the Committee to consider if the misconduct:

a. is easily remediable,
b. has been remedied; and
c. is highly unlikely to be repeated.

38. The Committee was also directed to *Fopma v General Medical Council* [2018] EWHC 714 (Admin). Mr Olphert cited paragraph 39 thereof:

> "*Put the other way round, 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 in question need not have regulatory consequences. If that, depending on the nature of the conduct in question, would itself be an unacceptable conclusion, then that can in any given case be a sufficient basis in itself to justify or indeed compel a conclusion of impairment.*"

39. The Registrant accepted that their actions amounted to misconduct but stated that their fitness to practise is not currently impaired.

40. The Registrant accepted that his conduct had fallen short of professional standards. He submitted that he had shown insight into his conduct. He stated that he had undertaken significant CPD courses to address the gaps identified by these allegations. The Committee was taken to certificates and reflections from the Registrant.

41. The Registrant submitted that the failings had come about whilst the Pharmacy struggled to cope with the impacts of the COVID-19 pandemic. He highlighted that this period had shown an increase in demand for online pharmacy services. He

stated that he had spoken to other pharmacies and that his practise appeared to broadly mirror these other pharmacies. He submitted that he only had sight of guidance from 2019 relating to dependence. He was unable to identify any other guidance that he had consulted during this time.

42. The Registrant submitted that by stepping back from all online pharmacy work and had sold the Pharmacy. He intended to work as a locum community pharmacist. The Registrant submitted that it was his overall aim was to work either as a community pharmacist, or as a primary care pharmacist within a GP surgery. He stated that he had stepped away from all managerial responsibilities. The Committee noted that the Registrant sold the Pharmacy's private online prescribing business, which completed on 3 September 2025. The NHS distance selling arm was also sold, which completed on 31 January 2026. The Registrant ceased acting as an SI on 1 February 2026.

43. It was, thus, the Registrant's submissions that the failures in his conduct were remediable, had been remediated and would not be repeated due to the changes he had brought about within his practise.

44. The Committee was also taken to testimonial evidence which spoke of the Registrant's commitment to patient safety and learning.

Decision on misconduct

45. When considering whether the particulars found proved amounted to misconduct the Committee took into account the *Good Decision making guidance*: *Fitness to practise hearings and outcomes Guidance 2024* (The 2024 Guidance)

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

    a. Standard 1 – provide person-centred care

    b. Standard 2 – work in partnership with others

    c. Standard 3 – communicate effectively

    d. Standard 4 – maintain, develop and use their professional knowledge and skills

    e. Standard 5 – use professional judgement; and

    f. Standard 9 – demonstrate leadership.

47. 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).

48. The Committee had regard to the wide-ranging failures and the severity of the risks associated with them. It was clear that the lack of governance, control and oversight displayed by the Registrant had contributed to failures to meet the standards noted above.

49. The Committee also noted that the Registrant accepted these failures and accepted that they amounted to misconduct.

50. Accordingly, the Committee concluded that, in its judgement, the grounds of failing to provide person-centred care, working in partnership with others, communicate effectively, maintaining, developing and using professional knowledge and skills, using professional judgement and demonstrating leadership were all established, and amounted to professional misconduct.

51. The Committee therefore did go on to consider whether the Registrant's fitness to practise is impaired.

Decision on Impairment

52. 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 / omissions of the Registrant:

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

53. The Committee was of the view that, whilst there was some insight on the part of the Registrant, this was limited. In particular, when asked, the Registrant stated that he had based his conduct on speaking to other pharmacists adjusting to a predominantly online practice during the COVID-19 pandemic. However, the Committee was surprised that the Registrant stated that he only consulted a single set of guidance during what was evidently a considerable transition in his working model.

54. There was a clear lack of oversight and failure in governance that presented an actual and potential risk to patients. It was evident that these risks had the potential to undermine the public's confidence in the pharmacy profession as a whole; and that

the Registrant had breached fundamental principles of the profession (as noted at paragraph 46 above).

55. The Committee noted that the Registrant was no longer working within a predominantly online structure, that he had stepped away from managerial positions and that he was not prescribing. The Committee also accepted that ultimately, the Registrant would wish to work as a community pharmacist or as a primary care pharmacist in a GP surgery.

56. Nevertheless, the Committee accepted that the submissions of Mr Olphert that the failings in the Registrant's professional conduct were so grave that the Committee was compelled to find impairment. The Committee accepted that it would undermine the public's confidence in the profession as a whole if such a finding was not made.

57. The Committee therefore finds the Registrant's current fitness to practise to be impaired on public protection and interest grounds and accordingly went on to consider the issue of outcome.

Decision on Outcome

58. 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.

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

60. The Committee had regard to the Council's 2024 Guidance to inform its decision.

61. The Committee took into account the submissions made by Mr Olphert and the Registrant.

62. Mr Olphert submitted that the gravity of the misconduct was such that only a suspension was appropriate. He accepted that conditions of practice were workable and the Committee may consider this appropriate if such conditions were carefully constructed so as to protect the public and maintain public confidence in the profession. Nevertheless, the Council's position was that a period of suspension with a review was the only appropriate outcome in this matter.

63. The Registrant submitted that the specific conditions that had led up to Patient A's tragic death had been addressed. The Registrant was neither prescribing nor working in a predominantly online setting. The Registrant therefore submitted that conditions of practice would meet the regulatory concerns that had arisen in this matter. The Registrant also directed the Committee to some CPD courses that he had undertaken since. He further submitted that issuing conditions of practice would help him gain further insight. The Committee asked him if he could continue to work within pharmacy settings, albeit not as a pharmacist, should the Committee issue a suspension. He maintained that he would need to continue working as a pharmacist to build true insight.

64. The Committee first considered what, if any, aggravating and mitigating factors there may be.

65. The Committee identified the following aggravating factors, including:

    a. the duration of misconduct, approximately two years,

    b. the level of harm that resulted; and

    c. the risk of far more widespread harm occurring.

66. The Committee identified the following mitigating features including:

    a. the Registrant accepted that the conduct amounted to misconduct early,

    b. the Registrant's co-operation with the Council; and

    c. the Registrant's remorse.

67. The Committee also considered the following factors to be relevant. The risks taken by the Registrant in this matter were manifold. There was a complete failure of risk management, governance and oversight that led to Patient A's death. Given the circumstances, it is only a matter of good fortune that patient harm was not more widespread.

68. The Committee accepted that the Registrant had addressed the very specific prescribing circumstances that led to Patient A's death. However, the Registrant did not seem to fully grasp how he had created the conditions that allowed extreme

risks, such as the death of Patient A, to materialise. The Committee accepted that the COVID-19 pandemic did bring a sudden shift to working patterns, but this was all the more reason for the Registrant to have been cognisant of the necessity for risk management, an evolving governance structure and heightened oversight.

69. The sheer volume of prescriptions outlined in the allegations, which amounted to 18,683, that were issued reflects the cavalier attitude the Registrant took to patient safety, and the Committee accepted Mr Olphert's submission that the Registrant had chosen to prioritise volume of distribution over and above patient safety. The Committee is acutely aware of the catastrophic consequences of this choice taken by the Registrant.

70. To take no action. Given the findings of the Committee, this could not be an appropriate outcome.

71. Warning. Given the findings of the Committee, this could not be an appropriate outcome.

72. Conditions of Registration. The Committee next considered the imposition of Conditions of Registration. A Conditions of Registration Order would allow the Registrant to practise albeit with restrictions. The Committee must determine whether a Conditions of Registration 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 Registrant, the profession and the regulator, and sufficient to promote professional standards within the profession.

73. If conditions are to be imposed, the conditions must be relevant and proportionate to the concerns identified regarding the Registrant's practice. Conditions must be workable and susceptible to being monitored. The Committee must also be satisfied that the Registrant will comply with any conditions imposed.

74. The Committee noted both Mr Olphert and the Registrant accepted that conditions could be potentially workable in this matter. However, the Committee felt that there remained a significant risk posed to the public given the Registrant's lack of insight as to how the conditions that gave rise to the particulars of this case were created.

75. The Committee also determined that a Conditions of Registration Order would not be sufficient to mark the seriousness of the matter and would thus also fail to maintain public confidence in the Registrant, the profession and the regulator.

76. 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."

77. The Committee finds that the severity of the misconduct, and the level of harm that resulted demands no lesser outcome to protect public confidence in the profession. The Committee also finds that it is necessary to highlight to the profession as a whole that such extreme failures of governance, oversight and risk management are both inherently dangerous and unacceptable.

78. The Committee therefore imposed a 12-month suspension order.

79. Removal. Given the above conclusions, the Committee was of the view that removal would be an inappropriate outcome in this matter.

Review Hearing

80. This decision will be reviewed by the Committee before the outcome expires. A future Committee may be assisted by:

- Further reflection from the Registrant as to how his systems of governance failed.
- Reports/updates from any supervisors or mentors working within pharmacy settings with the Registrant.

Interim Measure

81. The Committee noted that the Registrant was not subject to any interim order.

Decision on Interim Measure

82. As the Committee has imposed a suspension order, it is noted that this substantive decision will not take effect until 28 days after the notice of this decision has been sent and/or until any appeal has been finally disposed of.

83. The Committee therefore imposed an interim suspension order pursuant to Article 60 of the Order. This was to protect the public and it being otherwise in the public interest.

84. This concludes the determination.