

General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote video link hearing

24 February 2026 – 4 March 2026

Registrant name:	Nichola Mary Johnstone
Registration number:	2038420
Part of the register:	Pharmacist
Type of Case:	Misconduct/Deficient Professional Performance
Committee Members:	Raj Joshi (Chair) Hanad Osman (Registrant member) Melanie Palmer (Lay member)
Committee Secretary:	Ivana Raimundova
Registrant:	Not present and not represented
General Pharmaceutical Council:	Represented by Unyime Davies, Case Presenter
Facts proved:	1-5
Facts not proved:	6-9
Fitness to practise:	Impaired
Outcome:	Suspension for 12 months
Interim measures:	Interim Suspension Order

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 **7 April 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, whilst working as the Pharmacy Manager for Tesco Pharmacy, Wallace Street, Stirling, FK8 1NP between September 2021 and April 2022 :

1. Did not conduct sufficiently careful clinical and accuracy checks in relation to one or more of the dispensing errors which occurred in Schedule 1.

2. Did not conduct sufficiently careful clinical and accuracy checks in relation to one or more of the near miss errors which occurred in Schedule 2.

3 On 29 December 2021 knowingly supplied Espranor to Patient A instead of Buprenorphine as prescribed.

4. On 23 March 2022 supplied Patient B with Penicillin where:

4.1 only 12 of the prescribed 40 tablets were supplied;

4.2 this was without Patient B's knowledge;

4.3 you made no attempts to contact Patient B after becoming aware of the dispensing error;

4.4 you did not report the error at 4.1 to the Regional Pharmacy Manager.

5. On 23 March 2022 supplied Patient C with Methadone in the absence of a valid prescription.

6. *Did not engage in Tesco's reflection process for the dispensing errors.*
7. *Did not provide written comments regarding dispensing errors as agreed with the Regional Pharmacy Manager on 15 February 2022.*
8. *Between 11 January 2022 and 30 March 2022 did not engage with the formal performance management process by not completing training to provide Pharmacy First Patient Group Directions ("PGDs").*
9. *On 17 March 2022 did not follow the safe custody regulations by failing to appropriately [SIC] store a Schedule 2 Controlled Drug (Targinact) in the CD cabinet and instead left it outside on a bench.*

By reasons of the matters set out above your fitness to practise is impaired by reasons of your misconduct and/or deficient professional performance.

Schedule 1

<i>DATE</i>	<i>DESCRIPTION</i>
<i>7 October 2021</i>	<i>Lucette prescribed. 2 boxes of Lucette and 1 box of Milinette supplied.</i>
<i>22 October 2021</i>	<i>Amoxicillin wrong strength supplied</i>
<i>18 November 2021</i>	<i>Duloxetine. Fortnightly instalment. Individual instalments placed into the same bag. Quantity error.</i>
<i>17 December 2021</i>	<i>Methadone error. Wrong quantity supplied.</i>

<i>20/21 January 2022</i>	<i>MST given instead of Sevredol.</i>
<i>Jan 2022</i>	<i>Pregabalin quantity error. Part of the dispensed quantity returned to shelf.</i>
<i>5 November 2021</i>	<i>Gabapentin split pack returned to shelf</i>

Schedule 2

<i>16/11/2021</i>	<i>Humulin M3 - Pens instead of cartridges</i>
<i>07/02/2022</i>	<i>Sildenafil – wrong strength</i>
<i>09/02/2022</i>	<i>Adapalene and benzoyl peroxide- Wrong item supplied</i>
<i>18/03/2022</i>	<i>Emozul caps instead of esomeprazole tabs. Wrong form.</i>
<i>18/03/2022</i>	<i>Wrong patients bag label. (Co-Codamol)</i>
<i>21/12/2021</i>	<i>Atorvastatin- Strength</i>
<i>31/12/2021</i>	<i>Algesal- Quantity</i>
<i>03/01/2022</i>	<i>Careline leg bag-Wrong label attached</i>
<i>10/01/2022</i>	<i>Co-codamol. Fortnightly prescription bagged incorrectly.</i>
<i>29/10/2021</i>	<i>Tegretol prolonged release. Form. 1 box was not prolonged release.</i>
<i>24/11/2021</i>	<i>Co-codamol form. Caps on prescription. Tablets given.</i>

<i>25/11/2021</i>	<i>QV gentle. Form error. Wash given instead of cream.</i>
<i>01/12/2021</i>	<i>Isosorbide 25mg Modified release caps. Form error.</i>
<i>01/12/2021</i>	<i>Dovobet ointment- form</i>
<i>10/12/2021</i>	<i>Simvastatin- strength error</i>
<i>06/10/2021</i>	<i>Cream in wrong patients bag.</i>
<i>17/11/2021</i>	<i>Sertraline strength</i>
<i>10/01/2022</i>	<i>Co-codamol -wrong quantity</i>
<i>26/01/2022</i>	<i>Co-codamol -wrong form</i>

Schedule 2 – amended

<i>Date</i>	<i>Description of incident</i>	<i>Evidence in support</i>
<i>16 November 2021</i>	<i>Humulin M3 - Pens instead of cartridges</i>	<i>[B/124] BS/16-03: Near miss log. Staff involved GW and NJ.</i>
<i>07 February 2022</i>	<i>Sildenafil – wrong strength</i>	<i>[B/144]:BS/16-13: Near miss log. Staff involved JC/ the Registrant</i>
<i>09 February 2022</i>	<i>Adapalene and benzoyl peroxide- Wrong item supplied</i>	<i>[B/146]: BS/16-14: Near miss log states VL and the Registrant were staff involved</i>
<i>18 March 2022</i>	<i>Emozul caps instead of esomeprazole tabs. Wrong form.</i>	<i>[B/148]: BS/16-15: Near miss log GW and the Registrant were staff involved</i>

18 March 2022	Wrong patients bag label. (Co-Codamol)	[B/148]: BS/16-15: Near miss log. SG and the Registrant staff involved
21 December 2021	Atorvastatin- Strength	[B/132]: BS/16-07: Near Miss log: ND and the Registrant were staff involved.
31 December 2021	Algesal- Quantity	[B/134]: BS/16-08: Near Miss log
03 January 2022	Careline leg bag-Wrong label attached	[B/136]: BS/16-09: Near miss log, NG and NJ
10 January 2022	Co-codamol. Fortnightly prescription bagged incorrectly.	[B/138] :BS/16-10: Near miss log, GW and the Registrant were staff involved
29 October 2021	Tegretol prolonged release. Form. 1 box was not prolonged release.	[B/122]: BS/16-02: Near miss log. NJ details only
24 November 2021	Co-codamol form. Caps on prescription. Tablets given.	[B/126]: BS/16-04 Near Miss Log
25 November 2021	QV gentle. Form error. Wash given instead of cream.	[B/126]: BS/16-04 Near Miss Log
01 December 2021	Isosorbide 25mg Modified release caps. Form error.	[B/128]: BS/16-05: Near mis log, MD and the Registrant were staff involved.
01 December 2021	Dovobet ointment- form	[B/128]: BS/16-05: Near miss log MD and the Registrant were staff involved.
10 December 2021	Simvastatin- strength error	[B/130]: BS/16-06: Near miss log. Similar packs mixed together.

<i>06 October 2021</i>	<i>Cream in wrong patients bag.</i>	<i>[B/120]: BS/ 16-01 Near miss log.</i>
<i>17 November 2021</i>	<i>Sertraline strength</i>	<i>[B/124]: BS/16-03: Near miss log. 'Cannot recall the reason'. The registrant was involved with another member of staff.</i>
<i>10 January 2022</i>	<i>Co-codamol -wrong quantity</i>	<i>[B/138]: BS/16-10: Near Miss Log,</i>
<i>26 January 2022</i>	<i>Co-codamol -wrong form</i>	<i>[B/142]: BS/16-12: Near Miss Log,</i>

Documentation

Document 1- Council's hearing bundle

Document 2- Council's skeleton argument

Document 3- Proof of service bundle

Document 4- Proceeding in absence bundle

Document 5- Health information form

Document 6- Screenshot of medical records

Document 7- Investigation plan

Document 8- Evidence matrix

Witnesses

Witness 1, BS, Deputy Superintendent Pharmacist, Tesco Stores- gave evidence at facts stage

Witness 2, SG, Regional Pharmacy Manager Tesco Stores at time of incidents - gave evidence at facts stage

Determination

Introduction

1. This is the written determination of the Fitness to Practise Committee at the General Pharmaceutical Council ('the Council').
2. This hearing is governed by *The Pharmacy Order 2010* ('the Order') and *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010* ('the Rules').
3. The statutory overarching objectives for these regulatory proceedings are:
 - a. To protect, promote and maintain the health, safety and well-being of the public;
 - b. To promote and maintain public confidence in the professions regulated by the Council; and
 - c. To promote and maintain proper professional standards and conduct for members of those professions.
4. The Committee also has regard to the guidance contained in the Council's *Good decision making: Fitness to practise hearings and outcomes guidance* as revised March 2024.
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.

Conflict of Interests

None

Service of Notice of Hearing

The Committee has seen a proof of service bundle dated 23rd January 2026 from the Council headed 'Notice of Hearing' addressed to the Registrant and sent to their registered email address and postal address as noted on the Register. The Registrant was not in attendance nor was there a representative for the Registrant.

6. The Committee noted that a phone call had been made to the Registrant **PRIVATE** and an email dated 2nd July 2025 confirmed amended details for the Registrant. Subsequent correspondence was sent to the new address and this was signed for with photographs of receipt. Subsequent correspondence dated 9th of February 2026, giving notice of the hearing was signed for as received by "Nichola" on 10th February 2026. 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 proceed in the absence of the Registrant

7. The Registrant was not in attendance at this hearing, nor was someone attending on their behalf. The Committee heard submissions from Ms Unyime Davies, on behalf of the Council to proceed in the absence of the Registrant under Rule 25.
8. The Committee noted the hand-written correspondence from the Registrant dated 16th February 2026 which stated that she wished to "*tender my resignation from the General Pharmaceutical Council with Immediate effect*" **PRIVATE**". Subsequent to that letter the Council sent a letter dated 19th February 2026 acknowledging the letter but sending out forms for voluntary removal. The letter from the Council appeared to have been received by the Registrant on 23rd February 2026, the day before the hearing.

9. The Committee was concerned to clarify the position of the Registrant as there was a note of a phone call with the Registrant, dated 5th May 2026, **PRIVATE**, spoke of representation through a firm of solicitors and was not fit to attend.
10. The Committee therefore directed that a phone call was made to clarify the position, especially as the letter dated 19th February regarding voluntary removal had an incorrect postcode.
11. The Case Presenter said that telephone contact had been made with the Registrant **PRIVATE**.
12. The Committee considered the factors to take into account in line with **R. v Jones (No.2) [2002] UKHL 5; GMC v Adeogba and GMC v Visvardis [2016] EWCA Civ 162**. The Committee decided to proceed in the absence of the Registrant for the following reasons:
 - The Committee has found good service of the Notice, therefore the Registrant is aware of today's proceedings. The Committee have therefore considered that the Registrant has chosen to voluntarily absent themselves from this hearing.
 - Correspondence from the Registrant indicated that they would not be in attendance at this hearing and they did not ask for an adjournment.
 - The Council had contacted the Registrant regarding this hearing and the Registrant had written on the 16th February 2026 stating: **PRIVATE** The Committee understood this to mean that the Registrant did not wish to engage or attend further.
 - There was no information to suggest an adjournment would result in the Registrant's attendance in future.
 - There is a public interest in the expeditious disposal of cases.
 - Not proceeding today would inconvenience witnesses who are ready to give evidence.

Application to amend the particulars of allegation

13. The Committee heard an application from Ms Unyime Davies under Rule 41 to amend particulars of the Schedule to Charge 2 to as above. The application was made on the basis there were errors in the presentation of Schedule 2.
14. The Registrant was not present to oppose the proposed amendments.
15. The Committee was of the view that there was no material difference to Schedule 2 other than in appearance and no prejudice would be caused to the Registrant and therefore the amended Schedule 2 was substituted for the old Schedule 2.

Application for the hearing to be held in Private

16. The Committee heard an application from the Ms Unyime Davies under Rule 39(3) to hold parts of the hearing in private.
17. The Registrant was not present to make representations.
18. The Committee decided to hold certain parts of the hearing in private **PRIVATE**.

Registrant's response to Particulars of allegation

19. The Registrant had made it clear, through a lack of engagement and non-attendance, that she did not intend to respond to the charges.

Background

20. The Registrant is a pharmacist who was employed as the Pharmacy Manager at Tesco Pharmacy, Wallace Street, Stirling, between September 2021 and April 2022. During this period, the pharmacy operated routine systems for recording dispensing errors and near-misses, including Patient Incident Reports and Near Miss Logs. The Registrant had

previously been employed for 19 years at Maryhill dispensary, latterly as Superintendent Pharmacist.

21. From October 2021 onwards, a number of incidents were recorded involving a range of medicines. These included errors relating to strength, form, quantity, labelling and, in some cases, the wrong item being supplied. The Registrant was involved in a high number of these incidents in some capacity. These incidents were documented in the pharmacy's reporting systems and reviewed by management.
22. On 11 January 2022, the Registrant met with her Regional Manager, SG, for a "Let's Talk" informal meeting to discuss performance concerns. Further "Let's Talk" meetings took place on 15 February 2022 and 14 March 2022. An Action Plan meeting was held on 8 March 2022. These meetings addressed issues relating to dispensing accuracy, reflection processes, and completion of required training.
23. In February 2022, Tesco initiated a High Incident Review due to the number of reported incidents within a 26-week period. A report was produced summarising the incidents and the steps taken locally to address them.
24. On 23 March 2022, two further incidents were recorded. One involved Patient B, who received fewer tablets than prescribed. Another involved Patient C, who was supplied methadone in circumstances where the validity of the prescription later became an issue. These matters were discussed at an investigatory meeting on 29 March 2022, attended by the Registrant and management representatives.
25. On 1 April 2022, the Registrant was suspended from her role pending further investigation. She resigned from her employment on 21 April 2022.

26. On 4 April 2022, BS, Deputy Superintendent Pharmacist for Tesco, referred concerns about the Registrant's fitness to practise to the General Pharmaceutical Council. The referral included internal documentation, meeting notes, incident logs and related materials.
27. The Committee went on to
- receive evidence and submissions regarding the disputed particulars.

Decision on Facts

28. In reaching its decisions on facts, the Committee considered the documentation listed at the start of this determination, oral evidence and the submissions made by the Council and Ms Davies on behalf of the Council.
29. 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.

You, a registered pharmacist, whilst working as the Pharmacy Manager for Tesco Pharmacy, Wallace Street, Stirling, FK8 1NP between September 2021 and April 2022 :

Particular 1: Did not conduct sufficiently careful clinical and accuracy checks in relation to one or more of the dispensing errors which occurred in Schedule 1.

30. The Committee took into account relevant evidence from the Council. The Committee was of the view that the Registrant was an experienced pharmacist who had a number of years' experience prior to joining the Tesco Pharmacy team. She had been a

Superintendent Pharmacist prior to the commencement of her role at Tesco and had been used to being the sole person in charge. The errors highlighted in Schedule 1 were of a basic nature. The Registrant knew that she was working in a high-risk environment and was involved in both, dispensing and accuracy checking of prescriptions; she would know the consequences of her actions. It was also clear that Tesco had a number of requirements for the operation of the pharmacy section which included detailed Standard Operating Procedures (SOPs). In addition, as a result of her experience, the Registrant would be aware of the relevant rules and regulations, particularly as regards the system of checking names of medicines, quantities, strengths, and forms of medication such as tablets or capsules.

31. The Committee considered all the matters in Schedule 1 and found evidence of basic errors listed in each of the instances listed in Schedule 1.

This particular is found proved.

Particular 2: *Did not conduct sufficiently careful clinical and accuracy checks in relation to one or more of the near miss errors which occurred in Schedule 2.*

32. The Committee took into account relevant evidence from the Council. The evidence of BS was considered by the panel in respect of Schedule 2 (as amended) to be cogent and reliable. Of particular concern from the logs was the high percentage of errors attributable to the Registrant. The Committee was of the view that the records were made contemporaneously and whilst the individuals were under a duty to record matters accurately. The Committee took account of each matter in Schedule 2 and noted that the 10 January 2022 Co-codamol near miss error appears twice in both Schedule 2 and Amended Schedule 2.

This particular is found proved.

Particular 3: On 29 December 2021 knowingly supplied Espranor to Patient A instead of Buprenorphine as prescribed Wallace Street, Stirling, FK8 1NP between September 2021 and April 2022 :

33. The Committee considered the evidence and found that the Registrant supplied Espranor instead of Buprenorphine as she thought that the two were interchangeable. The Committee considered the records at pages 190 and 193 of Document 1. It was striking that the Registrant admitted that she did know there was a difference between Espranor and Buprenorphine, however she did not realise there was a difference in their bioavailabilities.

This particular is found proved.

Particular 4: On 23 March 2022 supplied Patient B with Penicillin where:

- 4.1 only 12 of the prescribed 40 tablets were supplied;***
- 4.2 this was without Patient B's knowledge;***
- 4.3 you made no attempts to contact Patient B after becoming aware of the dispensing error;***
- 4.4 you did not report the error at 4.1 to the Regional Pharmacy Manager.***

34. The Committee considered the relevant exhibit BS/09. It was plain that the prescription contained the name, amount and the period for which the penicillin was required. Additionally, there was the date and stamp of the prescribing dentist with the address. The Registrant had not supplied the correct amount. The contemporaneous interview notes with SG, the Regional Pharmacy Manager, signed by the Registrant, make it clear that the Registrant did not consider telephoning the dentist whose details were on the prescription, so that the patient could be contacted. The error was not notified to Ms SG.

This particular is found proved.

Particular 5: *On 23 March 2022 supplied Patient C with Methadone in the absence of a valid prescription.*

35. The Committee considered the documentary evidence at BS/07 and the dispensing record at BS/08. The prescription amounts and dates on the prescription and the notes were clear. The Registrant had simply not realised that the prescription had run out and had not looked at the dose to be supplied. The Committee found it troubling that a similar Methadone error had occurred on 17th December 2021 (Schedule 1) and this incident had happened within 3 months of the previous error.

This particular is found proved.

Particular 6: *Did not engage in Tesco's reflection process for the dispensing errors.*

36. The Committee considered the statements, exhibits and the live evidence of Ms SG. The Committee note that the only policy document which the Council had put in evidence was Exhibit BS/13 which set out Tesco's policy in relation to Complaints; Prescription dispensing; Clinical and legal assessment; Accuracy check and Transfer to the customer.
37. Neither Council witness provided any evidence of a duty or obligation in relation to engagement in Tesco's reflection process. The Committee was not provided with any policy or guidance on staffing or disciplinary matters. The witness SG could not recall a great deal of the matters contained in her statement, and the Committee specifically asked for relevant evidence. Whilst we had notes from the "Let's Talk" meetings, the witness did not provide any evidence on this point. The evidence was that there were a number of meetings which were said to be informal but led to disciplinary action nonetheless. The witness, trying her best, could recall some of the discussions but could not remember whether she received material or was unclear as to what material had been received. From the documentation, it was clear that the Registrant was asked to complete a number of actions whilst still managing the day-to-day work. The

Committee was not given evidence by Ms SG about what she recalled receiving, save to say that she did receive certain things. Additionally, the Committee had considerable difficulty disentangling Tesco's internal disciplinary practices from the obligations of the Registrant's pharmaceutical practice. The Committee found no evidence to suggest that the weekly meetings, which the Registrant attended, were not a part of the reflection process.

This particular is found not proved.

Particular 7: Did not provide written comments regarding dispensing errors as agreed with the Regional Pharmacy Manager on 15 February 2022.

38. The Committee found evidence of the Registrant having weekly meetings with Ms SG. Additionally, Ms SG was informed that consequences would result because of the dispensing errors. In the meeting of 15th February 2022, the evidence is of a number of matters being raised and the Registrant replying that she is working through the error reports and is feeling overwhelmed and would seek to consult her GP. The Registrant is informed that there would be a referral to the **PRIVATE**. The Notes read as follows: *"Review role pack again so that you understand what is expected of you as a manager. Please submit to me an action plan of what support is needed to ensure that you can complete these tasks and manage the department. To include timeline for completion of SOPs and curriculum. This is to be submitted in writing to SG by next Thursday."* However, the notes also state that there is to be a face-to-face meeting the following Thursday. Once again there is no evidence of the Registrant's obligations under any disciplinary process or policy.
39. The Committee considered that requirement may have been a matter for Tesco, especially since the notes read: *"If no plan submitted, activities not completed within timelines or no improvement seen this will be considered as your performance continuing to miss and we will take another step towards a formal performance process"*. SG, in her evidence, could not remember whether she had received the notes or not, and so there was insufficient evidence of this particular.

This particular is found not proved.

Particular 8: Between 11 January 2022 and 30 March 2022 did not engage with the formal performance management process by not completing training to provide Pharmacy First Patient Group Directions (“PGDs”).

40. The Committee found limited evidence of this particular. The Witness BS could not accurately remember what the acronym meant, let alone the obligation which it entailed. It was noted that the particular was required to be completed by the 1st April 2022. The Committee found no evidence of how this particular aspect fitted in with any curriculum training. The Registrant was presented with a number of tasks and expressed anxiety in relation to those tasks. The letter of suspension provided no evidence in relation to a failure regarding this training as it was about the bagging of a controlled drug. On the day of the expected completion, the Registrant was suspended from her job.
41. The Committee also sought further evidence on what the formal performance management process was, but there was no evidence of what the process was or how the non-compliance was to be dealt with. It was clear that the Registrant had been informed of weekly meetings, regular checks and other staff deployed to assist her. The Committee found that the Registrant had no choice but to be the subject of scrutiny over her time at the pharmacy. The formal disciplinary process had been started despite the Registrant stating that she felt overwhelmed. The Committee therefore found that she had engaged in all of the meetings and the notes make it clear that she did so, but there was no evidence of any standard with which she was to comply in relation to training.

This particular is found not proved.

Particular 9: On 17 March 2022 did not follow the safe custody regulations by failing to appropriately store a Schedule 2 Controlled Drug (Targinact) in the CD cabinet and instead left it outside on a bench.

42. The Committee considered the evidence under Rule 24 (2)(a) and **Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)**. The evidence by way of a report on this incident refers clearly to a witness to this incident. The report identifies the individual who was on duty. However, there is no witness statement from the individual. Counsel, Ms Davies could provide no information as to why a witness statement was not obtained for an incident which is now four years old by the Council. The Council did not make a hearsay application for this evidence nor explain any measures that might have been taken to obtain a statement or place the witness before the Committee or explain the absence of the witness. The Committee were of the view that the evidence, such as it was, was insufficient in any event. The witness did not directly observe the incident nor was there an explanation as to why the failure was attributed to the Registrant. The chain of custody between the Registrant and the item may have been accounted for by a number of reasons. Whilst the Registrant was not present at the hearing, the Committee had to fairly consider the deficiencies in the evidence, especially where it was hearsay and the Council had made no attempt to even obtain a statement.

This particular is found not proved.

Misconduct and Impairment

Misconduct

43. Having found some particulars of the allegations 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.

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

45. The Committee took into account the submissions made by Ms Davies. Ms Davies stated that the Registrant had made a large number of errors as found by the Committee’s decisions on facts in relation to the Schedules attached to Particulars 1 and 2. The errors had occurred in a relatively short space of time. Ms Davies submitted that:

- the errors were repetitive and could be regarded as serious;
- had persisted despite assistance;
- the Registrant lacked insight; and
- the Registrant’s fitness to practise was impaired.

46. Ms Davies then submitted that the Committee consider a Supplementary Bundle which contained the witness statement of Ms CC, a GPhC Case Officer, dated 21st May 2024. The Case Officer had obtained a GPhC Inspection Report dated 21st May 2021 and an Improvement Action Plan relating to Maryhill Dispensary where the Registrant had worked previously. The Committee decided that they wished to ask questions of this witness. Of particular concern, in line with the case of **Enemuwe v Nursing and Midwifery Council [2015] EWHC 2081 (Admin)**, the Committee was asked to consider the conclusions of the Inspection Report. The Committee sought to clarify with the witness the background to the witness obtaining this report, the chronology and the

relevance of an Inspection Report into the pharmacy to the misconduct and impairment stage. The Committee noted that the report was an inspection of the Registrant's previous pharmacy, albeit the Registrant was described as having the role of Superintendent. The Committee was concerned that, in the absence (though voluntary) of the Registrant, submissions on misconduct and impairment included material which may or may not have been served. The Committee was also apprehensive about the fairness and relevance of that material under Rule 24. Accordingly, the Committee decided that the witness was to give live evidence.

47. The Committee was informed on the date of the witness's attendance that the witness was sick. The Case Presenter submitted it was a matter for the Committee whether they wished to adjourn the case for the witness to attend or would proceed on the basis of the Supplementary Bundle alone. Ms Davies stated that the Registrant had been served with the bundle under the disclosure obligations imposed by Rule 14. The Committee decided that it was a matter for the Council whether an adjournment was sought for the attendance of the witness or whether a hearsay application was to be made. Ms Davies, on behalf of the Council, withdrew the Supplementary Bundle.
48. As a result of the Registrant's non-attendance, the Committee proceeded on the basis that the Registrant did not accept that their actions amounted to misconduct and that their fitness to practise is not currently impaired.

Decision on misconduct

49. 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 Guidance)*.

50. 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. Particular 1 - Standards 1,2,4,5
 - b. Particular 2 - Standards 1,2,4,5
 - c. Particular 3 - Standards 1,4,5,9
 - d. Particular 4 - Standards 1,2,5,8,9
 - e. Particular 5 - Standards 1,4,5,9
51. 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).
52. The Committee considered that fundamental errors had been identified in the charges. The Registrant was an experienced pharmacist of 19 years before she had commenced employment at Tesco. The Registrant had also been a Superintendent Pharmacist in her previous role and was the Pharmacy Manager with Tesco. The errors had occurred over a period of months and had been compounded by the fact that the Registrant continued making errors of a type and similar nature from September 2021 to April 2022. The errors were of the wrong medicine, the wrong quantity, the wrong dosage, and the wrong type. The risk to patients would have been obvious to any pharmacist. Schedule 1 sets out the medicines supplied erroneously and Schedule 2 sets out the "near misses". The errors were serious, especially in relation to controlled drugs, and because of the risks, patient safety was compromised. Any member of the public would be greatly concerned that a pharmacist was putting patients at risk.
53. Accordingly, the Committee concluded that, in its judgement, under Rule 5(2),

the following grounds are made out:

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

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

Decision on Impairment

55. Having found that Particulars 1 to 5 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 the actions 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;*

56. The Committee considered:
- a. The circumstances leading to the findings above are not remediable. Since the incidents occurred, the Registrant has provided no evidence of apology or remorse since she resigned from the post of Pharmacy Manager at Tesco on 1st April 2022.
 - b. The Registrant has shown little insight into the circumstances that led to the findings above. It is clear from the notes of the 'Let's Talk' meetings and action plans that the Registrant found it difficult to acknowledge what happened, to understand why it happened or to understand the impact of what happened.

- c. The Registrant has not remediated the circumstances by demonstrating regret and taking steps to prevent a repetition, for example through reflective practice, CPD or other training. The Registrant has not provided any information other than to say that she wishes to *“tender her resignation from the General Pharmaceutical Council with immediate effect”* in her letter dated 16th February 2026.
- d. The Committee therefore considers that there is a risk of repetition. In particular the Committee has seen nothing from the Registrant by way of training which has been effective and nothing to indicate that will reduce or eliminate the risk of repetition.
- e. The Committee considers that there is a risk of repetition and that such a repeat could cause harm to others. The Committee considers that what has happened could have caused actual harm.
- f. The Committee, having considered all of the evidence and its findings on facts, determines that the wider public requires a finding of impairment because there is a risk of future harm and, irrespective of any future risk of harm a finding of impairment is necessary to mark the seriousness of what has occurred and thereby maintain public confidence and promote professional standards by making clear to other professionals what is expected and deterring other professionals from failing to meet standards.
- g. And in doing so the Committee determines that the frequency of serious errors which could have compromised patient safety and even proved dangerous, along with the public interest in considering the actions of the Registrant and lack of any engagement throughout the fitness to practise process, presents a considerable risk.

57. The Committee therefore finds the Registrant’s current fitness to practise to be impaired on public protection and on public 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 it may in fact have a punitive effect. The purpose of the outcome is to meet the overarching objectives of regulation, namely the protection of the public, the maintenance of public confidence and the promotion of 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 '*Good decision making: Fitness to practise hearings and outcomes guidance*' to inform its decision.
61. The Committee took into account the submissions made by Ms Davies and the outcome proposed which was a suspension order for 9 months. The Committee agreed that the public interest was high in this case.
62. The Committee first considered what, if any, aggravating and mitigating factors there may be. In accordance with the case of *R (Uddin) v General Medical Council [2012] EWHC 1763 (Admin)*, paragraph 54 and *Giele v General Medical Council [2005] EWHC 2143 (Admin)*.
63. The Committee identified aggravating factors, including:
- No early admission of the facts
 - No apologies to anyone affected
 - No efforts to prevent similar things happening again, or any efforts to put problems right

- No evidence that the professional has worked safely and professionally in the same or similar role since the events causing concern
- No relevant training courses
- No reflective accounts or meaningful discussions with colleagues about what happened
- No evidence of keeping up to date with their area of practice.

64. The Committee identified mitigating features including:

- **PRIVATE**

65. To take no action. Bearing in mind the volume of breaches and the time over which such breaches had occurred this would not protect the public or serve the public interest.

66. Warning. For the reasons stated above in paragraph 64 and as the Committee had found impairment, this outcome would not be appropriate.

67. 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 determined that a Conditions Order would not be appropriate given the concerns identified regarding the Registrant's practice, in particular whether conditions would protect the public from harm, and 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. The Committee is not satisfied that the professional may respond positively to retraining and supervision. There is a significant risk posed to the public, and it is not safe for the professional to return to practice

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

69. The Committee in its determination of facts had found a number of serious errors which had the potential to cause harm to the public. In particular, there had been errors over the dispensing of controlled drugs. The errors were numerous and had occurred over a period of approximately six months and had occurred despite some form of support. The Registrant had made repetitive errors in form, quantity and substance in her capacity as a Pharmacy Manager.
70. The Registrant had resigned before a formal disciplinary process and had not worked since her resignation dated 21st April 2022 to Tesco. The Registrant had provided no evidence since that date of any remediation, reflection, training or testimonials. The Committee determined that the Registrant had breached the trust placed in her profession as a pharmacist due to the potential for very serious harm. Bearing in mind that the greater outcome of Removal is reserved for the most serious conduct, the Committee decided not to impose this outcome.
71. The contact from the Registrant had been sporadic and the phone call made on the first day of the hearing had shown a Registrant **PRIVATE**. The papers for voluntary removal had arrived the day before the hearing and the suspension order would also allow time for the Council to clarify whether the separate track process for voluntary removal was

an appropriate resolution. If the Registrant does not decide upon voluntary removal, the Council would be assisted by any further evidence of the Registrant's assertion that she wanted to resign because of her health. However, these are matters for the Council.

72. The Committee have determined that a Suspension Order of 12 months is imposed. Such a period would adequately reflect the serious nature of the Registrant's misconduct and would meet the overarching objective of public protection and would be in the public interest.

73. The Committee therefore directs that the Registrar **suspends Nichola Mary Johnstone for a period of 12 months.**

Review Hearing

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

- **PRIVATE**
- References or testimonials
- Evidence of continuing professional development and of any other training
- Any reflection statement or insight into her past employment

Decision on Interim Measure

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

76. The Committee heard submissions from Ms Davies regarding interim measures.

77. The Committee took account of the Council's guidance of March 2024 and interim measures provided for under Article 60 of the Order.
78. The Committee has decided that there has been misconduct and the Registrant's fitness to practise is impaired. The Committee has imposed a 12 month Suspension Order.
79. The interim measure is to cover any necessary appeal period and the circumstances where that should apply following an appeal. The interim measure is necessary to protect the public and is in the public interest.
80. This concludes the determination.