

General Pharmaceutical Council Fitness to Practise Committee

Principal Hearing - Remote videolink hearing

12-27 March 2026

Registrant name:	Abbas Ul Hassan Samnani
Registration number:	2084418
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Martin Winter (Legally Qualified Chair) Jignesh Patel (Registrant member) Jo Bower (Lay member)
Clinical Adviser:	Not applicable
Committee Secretary:	Chelsea Smith (12-20.3.26 & 25-27.3.26) Gemma Staplehurst (23.3.26) Mark Mallinson (23.3.26) Sameen Ahmed (24.3.26)
Registrant:	Present and represented by Michael Smalley
General Pharmaceutical Council:	Represented by Tom Hoskins, Case Presenter
Facts proved:	5.1 and 6
Facts proved by admission:	1, 2, 3, 4, 5.2-5.8, 8, 9, 10
Facts not proved:	7
Fitness to practise:	Impaired
Outcome:	Suspension for 12 months
Interim measures:	Nil

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 27 April 2026 or, if an appeal is lodged, once that appeal has been concluded.

Documentation

Document 1 – 1292-page GPhC bundle

Document 2 – Proposed Amended Particulars

Document 3 – GPhC Exhibit Matrix

Document 4 - GPhC statement of case

Document 5 – Registrant’s statement of case

Document 6 – Registrant’s bundle

Document 7 - 4-page index to Registrant’s bundle

Document 8 – Registrant’s 4-page statement

Document 9 – 16-page extract from unused material

Document 10 - Admissions

Document 11 – Exhibit reference SO01

Document 12 – Exhibit reference SO02

Document 13 - Extract from SO01

Document 14 - Response from GPhC to panel questions

Document 15 – Registrant’s testimonial from current employer (7 pages)

Document 16 - GPhC supplementary bundle re previous FtP finding (51 pages)

Document 17 – House of Commons publication re Covid 19

Witnesses

Ms Claire Crouch (CC), GPhC case officer - gave evidence at facts stage

Particulars of Allegation (as amended)

You, a registered pharmacist, whilst working as a Pharmacist Independent Prescriber (“PIP”) and/or in the role of Clinical Lead (“CL”) for UK Meds Direct Ltd, Unit 3 Castlebridge Office Village, Castle Marina Road Nottingham, England, NG7 1TN (“UK Meds”)

1. Between 23 October 2019 and 24 August 2022 prescribed and/or approved a total of approximately 70,618 prescriptions, including approximately 4,876 prescriptions for high-risk medicines and/or medicines requiring ongoing monitoring.

ADMITTED

2. In relation to 1, above, you routinely failed to prescribe medicines and/or failed to approve prescriptions in accordance with 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. failed to obtain adequate information in relation to patients’ health in advance of prescribing; **ADMITTED**

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

2.3. failed to access and/or attempt to access patients’ General Practitioner (“GP”) medical records and/or specialist clinical records in order to have a full picture of their: physical health; mental health; current prescribed medication; and/or addiction history; **ADMITTED**

2.4. failed to request a face-to-face or virtual consultation with patients and/or contact patients directly to adequately examine the clinical need for medication; **ADMITTED**

2.5. failed to adequately consider the possibility of medication dependence and/or misuse; **ADMITTED**

2.6. failed to refer patients back to their GP for appropriate assessment and/or review and/or monitoring; and/or **ADMITTED**

2.7. failed to put adequate safety-netting in place. **ADMITTED**

ADMITTED

3. In relation to 1, above, you prescribed medicines and/or approved prescriptions in circumstances where the UK Meds prescribing model or service was incapable of supporting safe prescribing decisions in that:

3.1. no face-to-face or other virtual consultation took place other than the use of a questionnaire; **ADMITTED**

3.2. patients provided information primarily through a questionnaire; **ADMITTED**

4. Your prescribing at 1, above, included the following medicines in the approximate quantities listed which are unsuitable to be prescribed only on the basis of an online questionnaire:

4.1. 185 prescriptions for opioids **ADMITTED**

4.2. 250 prescriptions for z-drugs **ADMITTED**

4.3. 46 prescriptions for Modafinil **ADMITTED**

- 4.4. 716 prescriptions for Circadin **ADMITTED**
- 4.5. 2128 prescriptions for Propranolol **ADMITTED**
- 4.6. 652 prescriptions for Amitriptyline **ADMITTED**
- 4.7. 782 prescriptions for weight loss medications Orlistat/Saxenda **ADMITTED**
- 4.8. 8848 prescriptions for Ventolin **ADMITTED**

5. On 31 October 2019, you prescribed/approved a prescription for 100 tablets of Codeine to Patient 2, a patient with a history of poor mental health and/or opioid dependence, in circumstances where you:

- 5.1. knew or should have known that that the Patient had made previous order(s) for the same medicine from UK Meds; **PROVED**
- 5.2. failed to obtain adequate information in relation to Patient 2's health in advance of prescribing **ADMITTED**
- 5.3. relied principally on the information received in an online questionnaire; **ADMITTED**
- 5.4. failed to access and/or attempt to access Patient 2's GP medical records and/or specialist clinical records in order to have a full picture of their: physical health; mental health; current prescribed medication; and/or addiction history **ADMITTED**
- 5.5. failed to request a face-to-face or virtual consultation with and/or contact Patient 2 in order to adequately examine the clinical need for medication; **ADMITTED**
- 5.6. failed to adequately consider the possibility of medication dependence and/or misuse; **ADMITTED**
- 5.7. failed to refer the Patient back to their GP for appropriate assessment and/or review and/or monitoring; and/or **ADMITTED**
- 5.8. failed to put adequate safety netting in place. **ADMITTED**

6. In relation to 1, above, you prescribed all or some of the medications outlined in Schedule A at the times, and to the patients identified in that Schedule in circumstances where you knew, or ought to have known, that the patient had made previous order(s) for the same medicine from UK Meds and you;

- 6.1. failed to adequately consider the possibility of dependence and/or misuse; and/or, **PROVED**
- 6.2. failed to ensure that monitoring and/or review had taken place in circumstances where the previous order was for condition(s) which required ongoing monitoring and/or review, **PROVED**

7. In your role as Clinical Lead, you oversaw the prescribing of other PIPs of all or some the medications outlined in Schedule A at the times, and to the patients identified in that Schedule in circumstances where you knew, or ought to have known, that the patient had made previous order(s) for the same medicine from UK Meds and you;

- 7.1. failed to adequately consider the possibility of dependence and/or misuse; and/or, **NOT PROVED**
- 7.2. failed to ensure that monitoring and/or review had taken place in circumstances where the previous order was for condition(s) which required ongoing monitoring and/or review. **NOT PROVED**

8. In your role as Clinical Lead you, together with another pharmacy professional, oversaw the prescribing of 25,854 high risk medicines and/or medicines requiring ongoing

monitoring to patients using the UK Meds model which was deficient for the reasons identified in paragraphs 2 and/or 3, above. **ADMITTED**

9. Your approach to prescribing in all or some of paragraphs 1 to 8, above, was transactional in that you were processing patient requests or overseeing prescribing by others by reference to a patient completed questionnaire rather than prescribing in accordance with UK prescribing guidance. **ADMITTED**

10. In relation to paragraph 1, from 7 September 2021 and until on or around 24 August 2022, you continued to work for UK Meds as a PIP and/or CL:

10.1. in a period when you knew or ought to have known that UK Meds was not registered with GPhC; and/or **ADMITTED**

10.2. without paying due regard to the registration status of your employer. **ADMITTED**

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

SCHEDULE A

Medicine	Date/time	Customer ID	No. Prescriptions approved by earlier UK Meds prescribers prior to Registrant
Codeine	31/10/2019 10.24	145097	2
Dihydrocodeine	26/10/2019 10.24	11322	30
Dihydrocodeine	31/10/2019 12.34	1235	25
Zopiclone	05/11/2019 22.24	59249	38
Amitriptyline	14/12/2020 14.57	76478	32
Amitriptyline	18/02/2021 10.21	127459	24
Amitriptyline	15/02/2021 11.38	2202	9
Propranolol	21/01/2021 12.15	209292	12
Propranolol	31/05/2021 07.46	119413	9
Propranolol	20/01/2021 23.23	225879	19
Ventolin	25/04/2022 11.00	28078	17
Ventolin	10/08/2022 20.47	38622	20
Ventolin	15/10/2020 12.01	31414	17
Tadalafil	02/04/2021 07.04	10885	45
Tadalafil	31/03/2022 12.46	277210	21
Tadalafil	18/08/2022 18.07	260042	36
Tadalafil	25/02/2022 11.32	238020	29
Tadalafil	28/02/2022 12.56	514681	2
Sildenafil	16/05/2022 10.10	41764	44
Sildenafil	28/04/2022 14.03	89070	41
Sildenafil	13/08/2022 13.40	60461	60

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 (Sanction) – 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 10 February 2026 from the Council headed 'Notice of Hearing' addressed to the Registrant and sent to their registered email address as noted on the Register. No issue was taken with service by either of the parties.
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 application from Mr Hoskins on behalf of the GPhC (under Rule 41) to amend particulars. The application was contained within the GPhC skeleton argument and reproduced below:

“6) These proposed amendments are, in part, non-substantive editing of the charges including:

a) Minor grammatical errors, omissions or deletions:

i) Including the abbreviation for Clinical Lead in the headnote and corresponding use of that abbreviation and PIP within allegations 7 and 10;
ii) Use of the plural to make it prescriptions for allegation 1;
iii) Correction of the grammatically incorrect “the patients” in allegation 2.1, and clarifying the references in allegations 5.1, 5.2, 5.4, 5.5 and 5.7 are specifically to Patient 2;

iv) Deletion of the phrase “that was completed” in allegation 9 as this is unnecessary.

b) Clarifying the allegations of repeated orders include instances where there has been a single earlier order rather than the unnecessarily complex formulation of “already made previous orders” which would require two or more previous orders, affecting allegations 5.1, 6 and 7.

c) Correction of the incorrect internal cross referencing between the numbered allegations and the consistent reference to “above” to make clear what earlier allegations are being referred to by later ones at allegations 4, 6, 7 and 9;

d) Clarification in allegations 2.3 and 5.4 of the types of health information that the use of medical records should have obtained in the reformulation to “physical health; mental health; current prescribed medication; and/or addiction history” to avoid unwieldy multiple iterations of the same charge which lose sight of the central concepts of failure to access sources of information to get a full picture of the health situation of patients.

7) The above amendments can be made without injustice to the Registrant since they are simply correcting unfortunate errors that have crept into drafting numerous, complex and cross-referring allegations. The changes proposed do not affect the overall substance of those allegations nor the alleged mischief therein identified. By virtue of this opening note served in advance of proceedings and the application being made at the outset of proceedings there

is sufficient time to take instructions on these issues. The evidence underlying the allegations has not changed.

8) In other respects, aspects of the application to amend the allegations are more substantive in nature. The GPhC proposes to do the following:

a) Rather than advance allegations by way of omission (“did not do x”) throughout the factual allegations, replace these with a “failed to do x”. This affects: allegation 2’s headnote and allegations 2.1 and 2.3-2.7 inclusive; allegations 5.2 and 5.3-8 inclusive; allegations 6.1 and 6.2 and allegations 7.1 and 7.2. This is a substantive change in that the meaning of the allegations have changed because the concept of a failure is a term of art, which requires that there be: a duty to perform a task; that the standard of that duty be established; and that the Registrant’s acts or omissions breach that standard. The justification for this change is threefold. First, at the facts stage it is fairer to the Registrant if the burden is on the GPhC to prove the duty and standard by way of guidance or otherwise rather than there being no burden at the later stages of the procedure (if reached). Second, if the existence or extent of a duty is a contentious issue it is better to explore these at the facts stage where the parties and the Committee have the benefit of hearing from the witnesses (most notably Dr C), rather than having the inconvenience of recalling them at any subsequent stages. It will also focus the themes of dispute for the attention of the Committee from the outset. Third, based on the submissions advanced by the Registrant before the Investigating Committee, the issue of a failure does not seem at issue and there may well be some admissions to the regulatory concerns. Not only does this negate any likely prejudice, it also reinforces the same consideration of the extent to which the allegations constituted a failure and are serious thereby would necessarily have to be conducted at the misconduct stage in any case so there is merit in having clarity from the outset;

b) In allegation 1, there is the addition of “approximately”. The gravamen of this allegation (upon which many other allegations reference or rely) is to give an idea of the scale of prescribing of both general prescriptions and those which it is alleged constitute high risk medicines and/or those that require ongoing monitoring. The GPhC have provided the evidence by which the figure of 70,618 prescriptions has been obtained [839 at §8], but to cater for any slight difference or inaccuracy, the insertion of the word approximately allows for some disparity with the exact figure without permitting the frustration of the gravamen of the charge and others contingent upon it by way of any slight arithmetical disparity;

c) In allegation 2 it is proposed to delete the “and/or pay due regard” from the headnote. This is because it detracts from the central mischief alleged which is that, at the material time, the Registrant’s prescribing failed to be in accordance with separate pieces of guidance from three separate sources in its outcome.

The issue of paying due regard incorporates unnecessary concepts such as the extent to which regard was had (if at all) at this time by the Registrant to the relevant guidance which detracts from the outcome-based mischief alleged. It also unnecessarily elongates the Committee's consideration of and deliberation upon this already complex charge which incorporates granular detail. There is no prejudice to the Registrant in this amendment because he is being effectively charged with fewer matters than the original draft and, should he wish to bring in evidence of the extent to which he paid due regard to the guidance but somehow failed in obtaining outcomes in accordance with it, there is nothing to prevent him from doing so in the usual way;

d) In allegation 2.4, the overly complex "to obtain details of their physical health and in order to assess the clinical need for medication", has been simplified to mirror allegation 5.5's "in order to adequately examine the clinical need for medication". As currently drafted, allegation 2.4 is limited to physical health alone which is inconsistent with other areas of relevant health information and so allegation 2.3. Additionally, the introduction of an interlocutory concept of the health subject areas obscures the central issue of clinical need for the medication whatever the various and myriad underling health conditions were. This clarification cannot prejudice the Registrant as it is, effectively, merely clarificatory;

e) In allegation 4.8, the "approximate quantity" of Ventolin prescriptions is currently alleged to be 8885, whereas the evidence of Ms Crouch [848-9] is that the total number of prescriptions was in fact 8848. Although this is apt to be covered by the phrase "approximate quantity" for the sake of specificity the GPhC seek this amendment at the outset. There is no prejudice by decreasing the quantity of alleged prescriptions for this medication as the underlying extent of misconduct remains consistent.

f) In allegation 5, it is material to the gravamen of the case that the evidence tends to demonstrate Patient 2 had a history of poor mental health and/or opioid dependence as outlined below. Although it is not specifically alleged that the Registrant in fact knew about this at the time of the prescribing decision, as can be seen from Allegations 5.5 and 5.6 what is alleged is that he should have done more to establish the existence of this. The GPhC propose to rely on Patient 2 as an illustrative example of the risk of harm occasioned by the prescribing practises by the Registrant while practising at UK Meds, and so their condition is a relevant factor in assessing the seriousness of the Registrant's prescribing practises more generally. Alleging the nature of Patient 2's condition within the charge allows any dispute of the records of the condition to be addressed prior to the consideration of seriousness and, additionally, is fairer to the Registrant in that the burden of proving this aspect of the facts is on the GPhC if it is specifically alleged.

g) In Allegation 5.5 there is the addition of a failure to contact Patient 2. The proposed amendment would correlate with the similar lack of consideration of other sources of medical information as alleged in allegation 2.4. This proposed amendment harmonises the allegations to the requirements identified in the relevant guidance and spoken to by Dr Campbell rather than potentially marking Patient 2 out as some special case where this default position of contact in the context of insufficient information was in some way not required. There is no prejudice to the Registrant for the reasons specified in the second sentence onwards of §7 above.

h) In allegations 6 and 7:

i) There is the cosmetic rearrangement by including the Registrant's actual or constructive knowledge of the repeated order within the headnote as it is common across both sub-allegations in each charge. This simplifies the drafting. This has the ancillary effect of requiring a clarification of allegations 6.2 and 7.2 by switching the order of the two concepts of failing to ensure monitoring or review (the mischief) and the condition precedent (the need for such monitoring/review). Again, this does not alter the substance of the charge and merely promotes clarity.

ii) There is a proposed deletion in the headnote of the reference to allegation 2. The gravamen of the allegation here is that part of the total prescribing was for repeated orders which marks it apart as more serious, not least in that within UK Meds there was information and a potential pattern available to the Registrant. It is unnecessary, duplication and will extend the Committee's enquiry to also examine again the alleged deficiencies outlined in allegation 2 again in the context of the repeated orders scenario as that has already been considered in respect of the totality of the prescribing alleged in allegation 1 (for which allegations 6 and 7 examine a sub-set of repeated orders).

iii) In Schedule A, there is a proposed replacement of the word "other" to describe previous PIP prescribers of the same medication to the same patient with "earlier" as it has always been apparent from the evidence of Ms Crouch that on some occasions the PIP who prescribed to that patient could also have been the Registrant himself, who cannot properly be described as "other". The evidence in support of this charge has always been clear on the witness statement of Ms Crouch and thus there cannot be said to be any countervailing prejudice.

i) Allegation 8 requires clarification of the central allegation that the model of UK Meds that the Registrant acted within and contributed to was deficient. The currently drafting of allegation 8 refers to the model being identified in

allegation 2 and 3, when in reality these identify the reasons that the model was overall deficient rather than the model in its totality. The mischief in allegation 8 is that during the time when the Registrant was CL, a high number of prescriptions for high-risk medicines or those requiring ongoing monitoring occurred by virtue of the same failures alleged in allegations 2 and 3. The redrafting of this allegations clarifies the mischief.

j) In allegation 10.1, the proposed amendment is to delete reference to “or any other UK Regulator”, the evidence focuses exclusively on the GPhC as regulator of the UK Meds entity and the history prior to the dates in the allegation demonstrate that UK Meds was hitherto regulated by the GPhC and came within its purview. There is no suggestion any other UK regulator such as the CQC or any issue of devolved powers for this England based entity should have somehow overtaken the regulatory responsibility for its regulation. As such, the concept of other UK regulators is not relevant to this case.

k) The incorrect use of and/or throughout the allegations:

(1) The addition of “and/or” to allegation 1 to replace the use of a “/” in allegation 1 to clarify that the concepts of high risk medicines and medicines which require ongoing monitoring are not exclusively alternatives but could be simultaneous concepts. The use of and/or is also consistent with the drafting elsewhere for clarity;

(2) A similar issue has arisen in allegations 2.5, 5.6, 6.1 and 7.1 where the concept of medical dependence and misuse had been joined by an “and” rather than the proposed “and/or”, which save for the amendment would require the Committee to be satisfied of both before finding the charge proved, whereas in reality the evidence and the gravamen of the allegation is that either or both of these concepts are sufficient to find them proven;

(3) The same is true in allegation 8, where the allegation of deficiency of the structure or model of the prescribing should be drafted as reliant on allegation 2 (fail to adhere to or consider prescribing guidance) and/or allegation 3 (factual features of the model), not necessarily both “paragraphs 2 and 3” as it had been drafted.”

9. Mr Smalley, on behalf of the Registrant, confirmed that he had been on notice of the proposed amendments and did not oppose them.
10. The Committee accepted the advice of the Legally Qualified Chair.

11. The Committee was of the view that the proposed amendments either clarified or simplified the particulars and did not create any unfairness to the Registrant. The Committee approved the amendments sought.

Application for parts of the hearing to be held in Private

12. The Committee heard an application from Mr Smalley for the Registrant under Rule 39(3) to hold parts of the hearing in private as there would be occasions when the Registrant would make reference to personal matters largely concerning his family members that were of a private nature.
13. Mr Hoskins did not oppose the application.
14. The Committee accepted the advice of the Chair.
15. The Committee decided to hold certain parts of the hearing in private as there will be reference to private matters for which the presumption of open justice would be outweighed by the requirement to protect the privacy of the individuals concerned.

Application to admit further evidence

16. Mr Smalley made an application under Rule 18(5) to admit, out of time, the Registrant's statement of case (Document 5), bundle (Document 6) and Registrant's witness statement (Document 8) into evidence. He conceded that the deadline for service of the Registrant's evidence (pursuant to Rule 18(3)) was 27 February 2026, 9 days prior to the Monday of the first week in which this hearing takes place. He had served the documents between 6 and 10 March 2026. He submitted that most of the new evidence was evidence of reflection and insight and accompanied confirmation that most of the particulars would be admitted.
17. The explanation advanced to the Committee was that an intervening period of holiday had interrupted the collating of the Registrant's paperwork and the timely submission to the GPhC in accordance with the Rules.
18. Mr Hoskins opposed the application on behalf of the Council. He drew the Committee's attention to the requirement for "*exceptional circumstances*" before an application for late service should be agreed and submitted that none existed in the grounds for the application.
19. The Committee accepted the advice of the Chair. The parties agreed that the lateness of service could be cured by simply delaying the start of the hearing until the week commencing 23 March 2026. However, the Committee concluded that would be a

wasteful use of hearing time. The Committee considered that the Registrant narrowly met the requirement of exceptional circumstances on the basis that the late-served evidence was largely evidence of reflection and insight and that any potential unfairness to the GPhC could be mitigated by allowing time during the hearing for the GPhC to scrutinise the Registrant's evidence.

Registrant's response to Particulars of allegation

20. The Registrant admitted particulars 1, 2, 3, 4, 5.2-5.8, 8, 9 and 10 and by the application of Rule 31(6) of the Rules, the admitted factual particulars were found proved.
21. The Committee went on to receive evidence and submissions regarding the remaining disputed particulars 5.1, 6.1, 6.2, 7.1 and 7.2.

Background

22. The Registrant faces allegations that his fitness to practise is impaired by reason of misconduct arising from his role as a Pharmacist Independent Prescriber ("PIP") and, latterly, as Clinical Lead ("CL") at UK Meds, an online pharmacy.
23. The Registrant was qualified as a PIP for approximately 14 months prior to his engagement at UK Meds. The Registrant's engagement at UK Meds as a PIP lasted from 23 October 2019 to 24 August 2022. He was an independent contractor rather than an employee and was paid a rate of £32 per hour and his pay was not contingent on whether he approved a prescription or refused it. The Registrant confirmed in oral evidence that he received an extra £1000 per month to reflect his role as CL.
24. Whilst a PIP, he had access to a CL to whom he could refer prescription requests if he was unsure whether to prescribe or not. The Registrant operated under a series of policies and standard operating procedures which subsequent GPhC enforcement actions indicated were inadequate to provide safe care.
25. The Registrant had indicated to the GPhC during the investigation that at the commencement of his employment he was impressed by what he saw as robust clinical processes and patient safety safeguards. However, he later came to realise that these systems and practises did not adequately support the high standards of care and safety that were initially portrayed.
26. The prescribing data provided to GPhC from UK Meds indicated that the Registrant prescribed on 70,618 occasions between 23 October 2019 and 24 August 2022. These prescribing decisions could cover more than one medication and included medication designated as high-risk or requiring ongoing monitoring on 4,442 occasions. This prescribing also included occasions where patients had obtained such

medicines on more than one occasion from UK Meds (in some instances from the Registrant himself) prior to the Registrant prescribing to them.

27. The Registrant was promoted within UK Meds and occupied the position of Clinical Lead (CL) between July 2020 and September 2021. He shared this role with another individual. The role of CL included supervisory responsibility over other PIPs and, according to UK Meds, part of the role involved contribution to the clinical governance under which the PIPs prescribed. The Registrant accepts his role as CL included a duty to challenge unsafe practises which, whilst claiming he sought to do, he concedes that his actions were insufficient.
28. During his time as clinical lead, the various PIPs at UK Meds prescribed on 257,559 occasions, of which approximately 1,896 were referred to the Registrant for review. There were 25,854 prescriptions approved by PIPs for high-risk medications or those requiring ongoing monitoring, of which the Registrant himself approved 171.
29. UK Meds was an online pharmacy operating 7 days a week. Its processes were as follows:
 - Customers would access its website and fill in an online questionnaire.
 - This questionnaire would be considered by a PIP working remotely. The PIPs would be supervised by the CL.
 - Where further follow-up was conducted with the patients this would be done over email or by phone generally by the PIPs themselves or escalated to the CL. The Registrant conceded that “Despite efforts to contact patients by phone for clarification or to request tests, reliance on questionnaires remained the primary method”.
 - There was infrequent communication with a patient’s GP either before or after the PIP’s prescribing decision, even where the questionnaire indicated that consent had been given by the patient for their GP to be contacted.
 - Following a prescription being issued by a PIP, it would be dispensed by the in-house pharmacy team from UK Meds and sent by post or courier.
30. In March 2019, UK Meds received a Statutory Improvement Notice due to concerns about vulnerable patients receiving inappropriate medicines. Required improvements included gathering full patient information, ensuring safe prescribing, safeguarding vulnerable clients, identifying misuse risks, and sharing prescription information with other healthcare professionals.
31. By May 2019, UK Meds was issuing roughly 750 daily orders, with persistent issues flagged in a follow-up visit by the GPhC. In September 2019, inspectors found systemic weaknesses such as inadequate risk assessments for high-risk medicines, over-reliance on patient questionnaires, minimal GP interaction, and lack of routine

consults or patient advice. Despite internal staff concerns, no corrective action was taken.

32. A second Statutory Improvement Notice was issued in September 2019, outlining required steps like risk assessments, website changes, mandatory GP contacts, and clear documentation when consent to contact a GP was withheld. By November 2019, the Pharmacy had not met these requirements and was subsequently prohibited from supplying Schedule 1–5 controlled drugs and modafinil. Updated guidance for pharmacist prescribers was published that month by the GPhC.
33. In October 2020, during the COVID pandemic, a further GPhC inspection revealed ongoing deficiencies in managing online medicine supply risks.
34. The allegations relate to the Registrant's prescribing practices and oversight responsibilities during his time at UK Meds. Each allegation addresses a specific aspect of professional conduct and patient safety, reflecting concerns raised by regulatory inspections and prescribing data.
35. Allegation 1 sets out the fact of the Registrant's role at UK Meds for the entire period where he appears within the prescribing data. It is based on this prescribing information that the GPhC assert the Registrant was a PIP and/or CL and he was evidently "working" for UK Meds within the headnote of all charges and "prescribing" as a PIP and/or "approved" the prescribing as CL.
36. Allegation 2 concerns the Registrant's routine prescribing practice in the context of the systems and procedures at the relevant time in operation throughout the period of his engagement at UK Meds. These charges describe a failure to act in accordance with relevant prescribing guidance.
37. Allegation 2.1 alleges failure to obtain adequate information prior to prescribing.
38. Allegation 2.2 concerns the Registrant's reliance principally on questionnaires.
39. Allegation 2.3 is the Registrant's failure to obtain (or attempt to obtain) GP or other records so as to have a full picture of current health and history of his patients.
40. Allegation 2.4 centres upon the failure to ensure any "face-to-face or virtual consultation" took place.
41. Allegation 2.5 asserts the Registrant routinely gave inadequate consideration to the risk of patients' dependence and/or misuse of medication he was asked to prescribe.
42. Allegation 2.6 concerns a failure to refer patients back to their GP.
43. Allegation 2.7 concerns the lack of provision of safety netting in place after a prescribing decision is made.
44. Allegation 3 covers concerns in relation to the fundamental safety of the prescribing model employed by UK Meds and is founded on observations of the GPhC inspection cycles inspection and the opinions that demonstrate the lack of any face-to-face or

other virtual consultation (Allegation 3.1); and reliance on a questionnaire (Allegation 3.2).

45. Allegation 4 concerns the instances of the Registrant's prescribing for specific medications that are regarded as more high risk by their nature as medicines liable to dependence, misuse or abuse.
46. Allegation 5 centres on the prescribing by the Registrant on 31 October 2019 for Patient 2 and the fact that the Registrant knew or should have known that Patient 2 had sought to obtain five previous orders from UK Meds.
47. Allegations 6 and 7 concern the Registrant's prescribing to 21 patients (set out in Schedule A) where the prescription was on a repeat occasion, meaning that same patient had had the same medication prescribed on at least one earlier occasion by a PIP at UK.
48. Allegation 8 focuses on the Registrant's role as CL and provides the total number of prescriptions made by other PIPs when he occupied this position between 4 July 2020 and 7 September 2021.
49. Allegation 9 asserts that the Registrant's actions were transactional, meaning that the Registrant was prioritising the revenue of UK Meds over the safety of the patients who were accessing the system.
50. Allegation 10 relates to a period after which UK Meds voluntarily de-registered from the GPhC register which meant they could no longer carry out activities as a pharmacy that they needed to be registered for and the Registrant continued to work as a PIP and/or CL.

Decision on Facts

51. In reaching its decisions on facts, the Committee considered the documentation listed at the start of this determination, oral evidence from the witness CC and the Registrant and the submissions made by the Council and the Registrant's representative.
52. The Committee accepted the advice of the Legally Qualified Chair.
53. When considering each particular of the 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.

Particular 5:

5. On 31 October 2019, you prescribed/approved a prescription for 100 tablets of Codeine to Patient 2, a patient with a history of poor mental health and/or opioid dependence, in circumstances where you:

5.1. knew or should have known that that the Patient had made previous order(s) for the same medicine from UK Meds;

54. The Committee took into account relevant evidence from the Council and the Registrant. The Committee noted that the Registrant accepted that he had prescribed the medication to Patient 2 and had admitted the other sub-particulars in respect of Patient 2. The sole area of dispute was whether the Registrant had properly considered the available history of previous orders made by Patient 2 through UKMeds.
55. The Committee noted the evidence contained within the GPhC bundle that had been provided by UKMeds during the overarching investigation. The Committee also noted the evidence given by the Registrant about how he approached prescribing for UKMeds and the systems in place at the relevant time.
56. The Registrant produced screenshots of examples of the information presented to him as a PIP that included the facility to click on tabs that would open a screen displaying the order history for the individual patient. Each patient would have a unique identity number and all previous orders related to that number would be displayed to better inform the prescribing decision of the PIP.
57. The witness CC explained how she had been provided with the spreadsheet evidence from UKMeds of over 800,000 orders and prescriptions made by UKMeds. These included prescriptions prescribed/approved by the Registrant but also by a number of other PIPs. CC had employed filters to this evidence to extract more refined and condensed data. This process resulted in Schedule A, a list of 21 patients that had each been prescribed medication by the Registrant despite a history of previous prescriptions from UKMeds that would suggest that further prescriptions should not have taken place. The Registrant's evidence set out that, had he considered the prescribing history for these patients, he would not have approved the orders. His defence in respect of Particulars 5.1, 6 and 7 was that his practice was always to check the history and his firm belief was that the full history must have been missing or incomplete.
58. Patient 2 is one of the 21 patients listed in Schedule A. The conspicuous difference between Patient 2 and the others on Schedule A is the level of detail known about this patient.

59. The background information contained in a Coroner's report and evidence from Patient 2's family confirmed that she had a long history of chronic pain for which she received medication from her GP. However, she fell into dependency and in April 2018 her GP refused to prescribe the medication that she was seeking.
60. Patient 2, who was a nurse by profession, thereafter engaged in forging prescriptions to obtain the medication and was also convicted of offences of dishonesty for which she received a suspended custodial sentence. She was disciplined by the Nursing and Midwifery Council for forging prescriptions and was struck off.
61. In August 2020 Patient A died as a result of a Codeine overdose. There is no evidence that the Codeine prescribed by the Registrant on 31 October 2019 was involved. During the subsequent inquest the coroner identified that after April 2018 Patient 2 had obtained medication from a number of online pharmacies including UKMeds without any inquiry being made of her GP records that would have identified Patient 2's dependency on medication, especially Codeine.
62. The Committee acknowledged that these factors demonstrated that, after her own GP refused any further prescriptions in April 2018, Patient 2 had a proven history of seeking to obtain medication by deceptive means and from multiple sources that included hiding her true identity to avoid prescribers knowing of her medical history
63. The Registrant put forward two scenarios that he suggested could explain the history being hidden from him. The first scenario was that the orders through UKMeds had not been attributed to the unique customer identity number for Patient 2. In support of this contention his representative, Mr Smalley, demonstrated that approximately 2050 orders on exhibit SO01 (the spreadsheet setting out all UKMeds orders) did not have a customer identity number associated with the order. However, these 2000 anomalies are within a total number of orders of approximately 880,000. Therefore, they represented approximately 0.23% of the whole. The Committee found that this scenario was so unlikely as to be entirely improbable.
64. The second scenario put forward by the Registrant related to separate customer identity numbers being "merged" from time to time. The Registrant was able to produce emails from UKMeds sent to him when he was acting as Clinical Lead where he was asked to approve the merging of two customer identities where UKMeds believed both customer identities related to one customer.
65. The Registrant gave evidence that this scenario occurred relatively frequently and was a result of security processes elsewhere in the UKMeds systems identifying that evidence suggested that separate customer identities related to a single person. He suggested that this most often occurred due to customers making small errors in the ordering process (e.g. the accidental misspelling of names or address details) that created unnecessary new customer identities. These were typically detected quickly

by UKMeds and the query forwarded to him to be resolved before the latest order was processed for the customer.

66. The Registrant suggested that the absence of a customer history for Patient 2 could be explained by multiple customer identities being used dishonestly by Patient 2, each of which contained only a fragment of her full medical history (or no history at all) and that these fragmented histories were only merged by UKMeds after he had prescribed Codeine in October 2019. This, he suggested, could account for why he prescribed the Codeine despite the history of previous orders for the same medication.
67. The Committee acknowledged that the evidence relating to Patient 2 was different to the other patients in Schedule A. Her history of misuse was evident from the coroner's report. Furthermore, her efforts and ability to continue to obtain Codeine after her GP had halted further prescriptions demonstrated her determination to avoid scrutiny and was likely assisted by her knowledge of the prescribing system gained as a nurse. It was also evident that she was prepared to resort to dishonesty to obtain the medication.
68. There was some evidence that Patient 2 had deployed the use of several email addresses and used her own son's identity to set up customer accounts with online prescribers.
69. Notwithstanding these factors, the Committee finds that there was no compelling evidence that the previous orders made through UKMeds were not available to the Registrant when he made the decision to prescribe 100 tablets of Codeine on 31 October 2019. There was no evidence that Patient 2 had used different details to successfully disguise her identity either on 31 October 2019 or on the previous occasions that UKMeds had prescribed medication to her. The evidence from the coroner's report suggested that the main device used by Patient 2 to avoid scrutiny was to make many applications for medication to various online prescribers. The inference the Committee has drawn from this is that Patient 2 had identified a general weakness across online prescribers that insufficient checks of each other's previous prescribing or of a central source (e.g. GP patient medical records) was being used.
70. The GPhC provided some clarification to the Committee regarding redacted information in the responses to questions posed during the UKMeds investigation. This confirmed that a single *aol.com* email address was used by Patient 2 for UKMeds orders. This was not consistent with the suggestion that Patient 2 was using multiple identities to deceive the PIPs at UKMeds. Furthermore, the clarification also confirmed that an order from Patient 2 was rejected on 6 November 2019 by the "anti-fraud measures" incorporated in the UKMeds systems because Patient 2 had

used a different email address. This demonstrated evidence of the robustness of the systems in place to detect potentially improper requests for medication.

71. The Committee also noted the evidence from the Registrant that he, when acting as clinical lead, had been asked by UKMeds to “merge” accounts that had belonged to the same person. The Committee accepts that this suggests that a single person could have more than one “customer identity number” with UKMeds at any one time and that this could lead to a fragmentation of the prescribing history. However, it is also clear from the evidence of the Registrant that these occurrences were relatively rare and were readily identified and quickly resolved by the systems in place and that the fragmentation of customers histories were, therefore, infrequent and of short duration.
72. The Committee finds it is highly improbable that Patient 2’s history of previous prescriptions via UKMeds was fragmented at all or, if it was ever fragmented, that the fragmentation could have endured long enough for the history to be unavailable to the Registrant on 31 October 2019.
73. The Committee is satisfied on the balance of probabilities that Patient 2’s prescription history was available to the Registrant on 31 October 2019 and he knew or should have known of this had he carried out proper checks.
74. This particular is found proved.

Particular 6:

6. In relation to 1, above, you prescribed all or some of the medications outlined in Schedule A at the times, and to the patients identified in that Schedule in circumstances where you knew, or ought to have known, that the patient had made previous order(s) for the same medicine from UK Meds and you;

6.1. failed to adequately consider the possibility of dependence and/or misuse; and/or,

6.2. failed to ensure that monitoring and/or review had taken place in circumstances where the previous order was for condition(s) which required ongoing monitoring and/or review,

75. The Registrant advanced the same defence here as in respect of Particular 5.1. For the reasons set out above, the Committee did not find that the explanations could be sufficient to displace the overwhelming available evidence. The UKMeds information clearly demonstrated that each of the Patients in Schedule A had a significant previous history of prescriptions from UKMeds and that, on the balance of probabilities, that history would have been available to the Registrant had he properly considered it.

76. The possibility of fragmentation of each patient's previous prescription history is even more unlikely given the volume of previous prescriptions through UKMeds for Schedule A patients other than Patient 2.
77. The Committee is satisfied that the Registrant failed to consider each patient's UKMeds history and therefore failed to adequately consider the possibility of dependence and/or misuse; and failed to ensure that monitoring and/or review had taken place.
78. This particular is found proved.

Particular 7

7. In your role as Clinical Lead, you oversaw the prescribing of other PIPs of all or some the medications outlined in Schedule A at the times, and to the patients identified in that Schedule in circumstances where you knew, or ought to have known, that the patient had made previous order(s) for the same medicine from UK Meds and you;

7.1. failed to adequately consider the possibility of dependence and/or misuse; and/or,

7.2. failed to ensure that monitoring and/or review had taken place in circumstances where the previous order was for condition(s) which required ongoing monitoring and/or review,

79. The Committee could not see from the wording of this particular nor the explanation in the GPhC statement of case (an extract of which is set out below) how this adds anything to Particular 6.

"Allegations 6 and 7 concern the Registrant's prescribing to 21 patients where the prescription was on a repeat occasion, meaning that same patient had had the same medication prescribed on at least one earlier occasions by a PIP at UK Meds or an allied pharmacy prior to the Registrant's decision...The distinction between allegations 6 and 7 is that in some instances the Registrant was engaged as a PIP, in others his decision occurred when he was engaged as CL."

80. All of the prescriptions detailed in Schedule A were prescribed by the Registrant and not "other PIPs". There was no evidence that any of the prescriptions were made as a result of a referral to the Registrant in his capacity as a clinical lead by another PIP.
81. Although the Registrant was also a clinical lead at UKMeds when he made some of the Schedule A prescription decisions, he was at all times acting in his capacity as a PIP.
82. This particular is found not proved.

Misconduct and Impairment

83. Having found some particulars of the 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.
84. 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."*
85. The Committee took into account the submissions made by Mr Hoskins and Mr Smalley. It also heard evidence from the Registrant.
86. Mr Hoskins submitted that the Registrant displayed a longstanding period of poor conduct in a high-risk environment that breached many of the Standards set out in the Standards for Pharmacy Professionals (May 2017) (the Standards).
87. Mr Smalley, on behalf of the Registrant, accepted that the findings of fact at Stage 1 amounted to misconduct but not that the Registrant's fitness to practise is currently impaired. He submitted that the overarching principles of fairness required the misconduct to be assessed in the context of a flawed system at UK Meds and that the misconduct was "situational" rather than "attitudinal". Reliance was placed on the comprehensive 546-page bundle of reflection and supportive evidence of remediation compiled by the Registrant.
88. The Committee accepted the advice of the Legally Qualified Chair.

Decision on misconduct

89. When considering whether the particulars found proved amounted to misconduct the Committee took into account the *Good Decision making: Fitness to Practice hearings and outcomes guidance* (revised March 2024) ("the Guidance")
90. 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 following Standards:
- a. **Standard 1: Pharmacy professionals must provide person-centred care** – the actions of the Registrant lacked person-centred care in a number of ways. The routine absence of adequate consideration of the available order/prescribing

history, the routine absence of direct communication with patients and the infrequent consideration of GP records all demonstrated that the Registrant had failed to employ a careful process of prescribing and adopted a transactional process of approving orders.

- b. **Standard 2: Pharmacy professionals must work in partnership with others** – The Registrant did not appropriately involve others in his practice at UKMeds. This included insufficient contact with GPs or his own colleagues.
- c. **Standard 3: Pharmacy professionals must communicate effectively** – the Registrant not only failed to adequately communicate with other professionals, but also the patients themselves.
- d. **Standard 4: Pharmacy professionals must maintain, develop and use their professional knowledge and skills** – the Registrant was a qualified pharmacist and PIP when he began work at UKMeds. He was sufficiently skilled and experienced such that he ought to have recognised the deficiencies in the UKMeds systems and acted accordingly. Instead, he allowed his practice to be compromised by working within the deficient systems of UKMeds.
- e. **Standard 5: Pharmacy professionals must use their professional judgement** – the Registrant put his training and skills to one side and allowed the convenience of the UKMeds system to displace proper practice. He did not adapt his practice to resolve the deficiencies in the UKMeds system and make the care of the patient his first concern and to ensure that he had the necessary information to provide appropriate care.
- f. **Standard 8: Pharmacy professionals must speak up when they have concerns or when things go wrong** – the Registrant should have recognised and raised concerns regarding the deficiencies in the UKMeds systems. It was demonstrated that he had the means by which to communicate directly with the directors of the company by email. The Committee acknowledges that the deficiencies might not have been immediately apparent to the Registrar upon starting at UKMeds, but the concession by the Registrant that he was not fully aware of these issues confirms that at some point he must have been at least partially aware and should have acted.
- g. **Standard 9: Pharmacy professionals must demonstrate leadership** – the Committee sought to resolve the dispute between the GPhC and the Registrant as to exactly what leadership responsibilities the Registrant assumed when taking on the role of Clinical Lead in July 2020. The UKMeds description of the role was as follows;

Clinical Lead duty, to review any referrals by other prescribers, regularly review a prescriber's decision-making, manage their working patterns and rota of other prescribers, keep their own and others training up to date, prepare and update policies and procedures.

- h. This definition of the role was disputed by the Registrant in that he did not accept that he had any role in the managing of work patterns or rotas of other PIPs or any involvement in policies and procedures. The Committee did not find any evidence that the Registrant was engaged in work pattern or rota activity but noted evidence that the Registrant was engaging in training supervision of the PIPs, review of referrals from PIPs and was liaising with the directors in respect of suggested improvements to the procedures at UKMeds including new review services of patients to alleviate problems caused by backlogs during Covid.
91. 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).
92. The extent to which the Registrant fell short of expected standards was significant and the Committee concludes is both serious and deplorable. This was a sustained and substantial deviation from professional norms.
93. At the commencement of his employment at UK Meds, the Registrant possessed significant experience in prescribing and pharmacy practice. He was adequately qualified, experienced and competent, and therefore fully capable of recognising and addressing shortcomings in the systems at UK Meds.
94. The findings of fact at Stage 1 paint a picture of repeated and widespread failures rather than isolated lapses in judgement. These failures occurred over a period of years but the seriousness is not merely reflected in the number of prescriptions issued or the timespan, but in the broad range of failures, which include a failure to obtaining sufficient patient information, a lack of person-centred care, and failure to share information with GPs.
95. There was a particular severity in the risks arising from the Registrant's actions regarding thousands of prescriptions for high-risk medications and these risks were not theoretical. Particular 5 demonstrates that these risks were very real. Although the Committee's findings do not suggest that the Registrant's prescriptions contributed to Patient 2's death, her case illustrates that the Registrant's failures had the potential for tragic real-world outcomes.
96. Despite the systems at UK Meds, the Registrant, as a PIP, had a clear professional duty to exercise independent clinical judgement regarding whether to prescribe. This duty is a crucial safeguard and cannot be avoided by placing responsibility onto the flawed UK Meds system. The Registrant was obliged to stop prescribing if these deficiencies were evident and patient safety was compromised. This duty was especially important in his role as Clinical Lead as this role required him to challenge

the UKMeds system and procedures through careful scrutiny of referrals from other PIPs.

97. The continued prescribing by the Registrant after UKMeds had voluntarily de-registered from GPhC demonstrates either a casual concern for regulatory oversight or, at the very least, a worrying lack of curiosity on his part.
98. The Committee concludes that the Registrant prioritised the UK Meds system over the fundamental requirement to provide safe care and this represents a significant and serious departure from the core values of pharmacy.
99. The Registrant asserted that he was not distracted from his professional duties at UK Meds by the personal circumstances concerning his parents. Nor does he assert that he was distracted by the NHS Counter Fraud investigation and subsequent GPhC Fitness to Practise proceedings that centred on frauds committed by the Registrant between November 2018 and August 2019 which culminated in a finding of misconduct and suspension on 17 November 2022.
100. The Registrant also asserted in evidence that he was never placed under pressure by UK Meds to take on more work than he could cope with. Notwithstanding the Registrant's assertions, his representative submitted that this was relevant context against which the findings of fact must be placed as was the overarching defective nature of the UK Meds systems.
101. The Committee agrees it is relevant context and the defective nature of the UK Meds system should not be ignored. But this does not change the role and responsibilities of a pharmacist especially in terms of high-risk medications. The same principles and standards apply and the online setting changes nothing. It might have made the environment unfamiliar and more complex for the Registrant, but the same standards that apply in the conventional pharmacy setting remained in place. Pharmacy professionals are expected to do the right thing in difficult circumstances. The Registrant did not do the right thing and his failings are serious and amount to misconduct.
102. The Committee therefore went on to consider whether the Registrant's fitness to practise is impaired.

Decision on Impairment

103. Having found that the particulars of the 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 the actions or 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.*

104. Mr Hoskins, on behalf of the GPhC, acknowledged the “impressive” levels of remediation demonstrated within the Registrant’s bundle of evidence and reflective statements. His main reservation was the absence of evidence that the Registrant has demonstrated that he is able to uphold proper standards within an unstructured and unconventional environment such as he encountered at UK Meds. The Registrant’s current employment is clearly within a surgery with high levels of support and governance where he has access to colleagues of a high calibre who can mentor and support his practice. The Committee noted the exemplary work the Registrant has carried out over the last few years as set out in a number of case studies.
105. The Committee noted the detailed and structured approach adopted in the Registrant’s written evidence was strikingly at odds with his presentation of oral evidence which was, at times, disjointed and erratic. The Committee noted the questions posed by Mr Hoskins to the Registrant as to whether he had used artificial intelligence (AI) to draft his written submission and the Registrant’s response that the words were his own and he only used the “Grammarly” software application to assist in correcting his grammatical errors. The Committee has approached his written submissions on the basis that they represent his own evidence.
106. The Committee is satisfied that the Registrant has demonstrated through his evidence that he has insight into the circumstances that led to his misconduct and, especially in his reflections concerning Patient 2, understands the impact of what has happened.
107. The targeted remediation that he has demonstrated via his work developing his practice in relation to opioid medications was particularly reassuring for the Committee. The verification of the Registrant’s recent good work through the testimonials provided by the surgery lead GP and managers carried significant weight.
108. The Committee is satisfied that the Registrant’s regret is genuine and he has taken positive steps through his practice and the completion of appropriate training and CPD. These steps reassure the Committee that the Registrant has remediated to a significant degree and reduced the risk of repetition accordingly. The case studies

submitted by the Registrant provide tangible evidence that the development in his learning and reflection has been utilised in his current practice.

109. These steps are commendable and reduce the risk of repetition. The Committee acknowledge the concerns expressed by Mr Hoskins on behalf of the GPhC that the Registrant has not been tested in a real-world environment that is unstructured or unorthodox, like UK Meds, and note the Registrant's unequivocal statement that he would never return to on-line prescribing.
110. The Committee is mindful that online prescribing is likely to become increasingly prevalent and, despite the assurances of the Registrant, it is foreseeable that he might at some stage return to prescribing online. This does leave the Committee questioning whether the Registrant's steps towards remediation are sufficient to reduce the risk of repetition should he leave the structured working environment that he currently enjoys. As he described in his written statement, in the system in which he currently works "*risk is neutralised by design*". The Committee carefully considered whether the Registrant could be trusted where such designs are absent.
111. The Committee accepts that risks in online prescribing can never be totally eliminated and the Registrant's impressive remediation has not addressed this specific area of concern. The Committee accepts that it is very difficult for the Registrant to provide evidence that he could return to an unstructured environment without the Registrant leaving the practice in which he is currently thriving to test himself in a less structured and unsupported pharmacy role. Placing such a hurdle before the Registrant is, in the view of the Committee, unrealistic and unreasonable.
112. The available guidance for online prescribing has evolved since the period the Registrant was at UK Meds and has strived to keep pace with developments in this fast-moving area of pharmacy. Controls are now more robust and it is likely that the Registrant would be better supported in such a role and his time with UK Meds would be a chastening experience that would undoubtedly inform his future conduct.
113. The Registrant has demonstrated that he has been exploring areas beyond the orthodox practice of his current employer and promoting novel areas. He has demonstrated via various case studies exceptional patient care to enhance the service for these patients. This included a study of patients receiving online prescriptions for weight loss medication to which he has applied the learning from his time at UK Meds to provide better support. The Committee is satisfied that he could be relied upon in an online setting or outside of the strong support structure in which he is currently practising. Therefore, any potential risk of repetition that remains is reduced to an acceptably low level, albeit not entirely extinguished. Therefore, the Committee does not find current impairment on a public protection basis.
114. Notwithstanding the considerations regarding public protection outlined above, the Committee is satisfied that the wider public interest in maintaining confidence in the pharmacy profession and declaring and upholding professional standards requires a

finding of impairment irrespective of any future risk of harm. Such a finding of impairment is necessary to mark the seriousness of what has occurred to maintain public confidence in the pharmacy profession and promote professional standards by making it clear to other professionals what is expected and by deterring other professionals from failing to meet standards.

115. The pharmacy profession has been brought into disrepute. UKMeds presented a significant risk to the public for a substantial period of time. The poor systems and practice placed the public at risk and consequently diminished the reputation of UK pharmacists. Public trust in the profession was harmed and the Registrant had a significant role in the UK Meds practice and in the harm that was caused.
116. The Committee therefore finds the Registrant's current fitness to practise to be impaired on public interest grounds .

Decision on Outcome (Sanction)

117. 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.
118. 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.
119. The Committee had regard to the Council's '*Good decision making: Fitness to practise hearings and outcomes guidance*' (revised March 2024) to inform its decision.
120. The Committee took into account the submissions made by Mr Hoskins and Mr Smalley and the Committee accepted the advice of the Chair.
121. The Committee first considered what aggravating and mitigating factors there may be.
122. The Committee identified the following aggravating factors:
 - a. The Registrant's misconduct was a significant and very serious departure from standards. In his role as Clinical Lead he had a more senior position within UK Meds and he failed to utilise his enhanced status to protect patients.
 - b. The misconduct extended for over 2 years with high-risk medicine prescribing which presented a substantial risk to patient safety, including vulnerable patients.

- c. The previous Fitness to Practise (FtP) proceedings that concluded on 17 November 2022, albeit different in nature, were largely concurrent with the period of misconduct that is the subject of these proceedings. This should have heightened the Registrant's adherence to proper behaviour and practise.
 - d. The Registrant's personal circumstances were prioritised above patient safety.
 - e. The potential for harm and impact on others was widespread and significant.
 - f. Registrant failed to raise concerns about the deficiencies at UK Meds and patient safety was thereby compromised. This was more acute when he took on the role of Clinical Lead.
123. The Committee identified the following mitigating features including:
- a. The extensive testimonials, reflection and insight demonstrated in the Registrant's bundle that has already been referenced by the Committee at the stage 2 findings.
 - b. The Registrant had indicated at an early stage to the Investigation Committee of GPhC that he accepted some wrongdoing, albeit the Particulars were not fully admitted and the admissions that were made were formally confirmed only at the outset of the hearing.
 - c. The Registrant had significant personal commitments towards family members in difficult circumstances.
124. The Committee considered the tentative assertion by the GPhC that the Registrant derived some financial benefit from his misconduct. The Committee is satisfied that such benefit only extended to the wages that he was paid during his employment at UK Meds and could not be properly considered to be an aggravating factor.
125. The Committee considered the available outcomes starting from the least serious, taking no action. The Committee was satisfied that given the findings of fact and analysis of impairment that this was not a suitable or proportionate outcome. The facts and context of this case are too serious.
126. The Committee next considered imposing a Warning, as suggested by Mr Smalley on behalf of the Registrant. The Committee acknowledges that this outcome can be sufficient to mark the wrongdoing of a pharmacy professional. However, the misconduct in this case is very serious and placed many patients (including vulnerable patients) at risk over a significant period of time. The seriousness of the departure from core standards satisfied the Committee that a warning would not sufficiently mark the gravity of the misconduct.
127. 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 this outcome would not be appropriate given the findings at Stage 2 regarding the Registrant's practice.

128. 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."

129. The Committee noted that the GPhC took the position that such an outcome was appropriate in this case. Mr Smalley submitted that, although accepting that public confidence in the profession must be maintained, that there was also a competing public interest in an otherwise competent pharmacist being able to continue to serve his community and wider public.
130. The Committee acknowledges the findings at stage 2 and agrees that the Registrant is currently providing a high level of service to his patients and that there are no future public safety concerns. However, the Committee is also satisfied that the seriousness of the misconduct set out in the findings of fact and the decision on impairment is so grave that any less a sanction than suspension would be inappropriate.
131. The Committee considered the correctness of this outcome by assessing the next more serious outcome, removal from the register. Removal from the register was an option within a reasonable range of potential outcomes. However, the steps of remediation taken by the Registrant satisfy the Committee that removal is neither proportionate nor necessary.
132. The Committee is of the view that the misconduct was so serious that only the maximum period of suspension of 12 months would be appropriate. The Committee acknowledge that this restriction will impact the Registrant and his patients but the public would expect no less an outcome.
133. The Committee agrees with submissions of both parties that a review is unnecessary in this case. There is no more that the Committee would wish to see from the Registrant before he can return to practice after the suspension has expired.
134. The Committee therefore directs that the Registrar to suspend Abbas Ul Hassan Samnani from the Register for the period of 12 months.

Decision on Interim Measures

135. Interim measures are provided for under Article 60 of the Pharmacy Order. Interim measures may only be imposed after an order for removal, suspension or conditions of registration. The Committee considered the Guidance in respect of interim measures.
136. Article 60 is set out below.

Interim measures pending a direction taking effect

60.—(1) Paragraph (2) applies where, under article 54, the Fitness to Practise Committee gives—

(a) a direction to remove a registrant's entry from one or more parts of the Register; or

(b) a direction for suspension.

(2) If the Fitness to Practise Committee is satisfied that to do so is necessary for the protection

of members of the public or is otherwise in the public interest or in the interests of the registrant, it

may order that the entry of the registrant who is the subject of the direction in the part or parts of

the Register to which the direction relates be suspended forthwith, pending the coming into force

of the direction.

137. Submissions were taken from both parties. Mr Hoskins conceded that this is not a public protection matter and there had been no interim order in place throughout these proceedings (although the Registrant was subject to a period of suspension following his FtP hearing in November 2022). However, he submitted that interim measures were necessary to give effect to the Committee's findings of the misconduct being particularly grave. Mr Hoskins conceded that the authorities (*NMC v Persand* (2023) *EWHC 3336* and *Sheikh v GDC* (see below)) confirmed that interim measures on public interest grounds are rare and that a high bar must be reached, that was equivalent to the requirement of necessity, to justify such an action.
138. Mr Smalley submitted that it was not necessary to put in place interim measures that would have the effect of displacing the default position that an outcome of suspension does not come into effect until the expiry of the 28 days appeal period. He cited the absence of any immediate risk to the public and that public confidence in the profession would not be harmed by the absence of such measures. He also submitted that the effect of such measures would be to extend the suspension beyond the maximum period of 12 months by a further 28 days and that had a punitive effect.
139. The Committee notes the observations from *Sheikh v GDC* [2007] *EWHC 2972* at paragraph 16 that it is "...a rare case where a suspension order will be made on an

interim basis on the ground that it is in the public interest” and the observations that although the condition of “necessity” is not attached to the public interest ground in Article 60 that it should be interpreted as being close to that requirement and certainly more than merely desirable. The Committee also noted that the authorities cited both referred to cases involving interim measures before a final FtP hearing.

140. The Committee does not find that this is one of those rare cases where the high bar has been reached and, as such, there is no necessity to impose interim measures in the public interest. Public confidence and the wider public interest are met by the suspension of 12 months, which is not designed to be punitive but to mark the seriousness of the misconduct. The will of Parliament set out in the Pharmacy Order makes clear the default position and the Committee does not find that the circumstances of this case establish any risk or necessity to impose interim measures in the public interest
141. The Registrant poses no risk from which the public needs interim protection and the concept of public interest is distinct from a theoretical interested member of the public who might be concerned that the suspension of this Registrant does not take immediate effect. Public interest considerations that displace the default statutory framework, even on an interim basis, must be substantial and the Committee is satisfied that there are insufficient grounds in this case.
142. The Committee’s 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.
143. This concludes the determination.