

General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote videolink hearing

20 April 2026 – 13 May 2026

Registrant name:	Mukesh Aggarwal (MA) Amarjit Singh Bassi (ASB) Sonia Aggarwal (SA)
Registration number:	2039486 2025424 2044050
Part of the register:	Pharmacists
Type of Case:	Misconduct
Committee Members:	Martin Winter (Legally Qualified Chair) Esosa Osakue (Registrant member) Sara Atkins (Lay member)
Legal Advisor	Vishal Misra (20.4.26 – 8.5.26)
Committee Secretary:	Adam Hern
Registrant:	Mukesh Aggarwal (present), represented by Anthony Haycroft. Amarjit Singh Bassi (not present) and not represented at hearing. Sonia Aggarwal (present), represented by Anthony Haycroft
General Pharmaceutical Council:	Represented by Tom Hoskins, Case Presenter

Facts proved:	ASB: 1-7, 8.2-8.9, 9, 10, 12, 13, 14
Facts proved by admission:	MA: 1-10, 11.2-11.9, 12, 13, 16, 17, 18, 19 SA: 1-9
Facts not proved:	MA: 11.1, 14, 15 ASB: 8.1, 11
Fitness to practise:	Impaired (All Registrants)
Outcome:	MA – 12 month suspension from the register ASB – removal from the register SA – 12 month suspension from the register
Interim measures:	Imposed

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 10 June 2026 or, if an appeal is lodged, once that appeal has been concluded. However, the interim suspension set out in the decision takes effect immediately and will lapse when the decision takes effect or once any appeal is concluded.

Particulars of Allegation (As Amended)

Mukesh Aggarwal

You, a registered pharmacist, whilst acting as a Responsible Pharmacist ('RP') and a director of JIT Laboratories Ltd t/a Homecare Pharmacy, ('the Pharmacy'),

1. Between around 30 December 2017 and 3 October 2018 provided pharmacy services at a distance together with UKMeds Direct Ltd ("UKMeds") supplying prescription-only medication.
2. In relation to paragraph 1, you dispensed, and/or oversaw the dispensing of approximately 28,070 prescriptions which included high-risk medicines such as amitriptyline, codeine, dihydrocodeine, zopiclone and zolpidem.
3. In relation to paragraph 1, you entered into a business arrangement to dispense prescriptions through UK Meds, without carrying out due diligence and/or assuring yourself that prescribers were appropriately safeguarding patients.
4. In relation to paragraph 1, you dispensed and/or oversaw the dispensing of high-risk prescription only medicines in circumstances where you had not assured yourself that they had been prescribed in accordance with the relevant guidance from the General Medical Council ('GMC'), the Royal Pharmaceutical Society ('RPS') and/or the General Pharmaceutical Council ('GPhC'), in that they were routinely prescribed in circumstances where prescribers:
 - 4.1 Failed to obtain adequate information in relation to patients' health in advance of prescribing;
 - 4.2 Relied principally on the information received in an online questionnaire;
 - 4.3 Failed to access and/or attempt to access patients' GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

- 4.4 Failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;
 - 4.5 Failed to adequately consider the possibility of medication dependence and misuse; and/or
 - 4.6 Failed to refer, or attempt to refer, patients back to their GP for appropriate assessment and/or review and/or monitoring.
- 5. In relation to paragraph 1, you dispensed and/or oversaw the dispensing of high-risk prescriptions to patients; including, but not limited to, all or some of the medicines and the patients outlined in Schedule A; where:
 - 5.1. You knew or ought to have known that patients had already made repeated orders for the same medicine or same type medicine from UK Meds; and/or
 - 5.2. Without adequately considering the possibility of medicine abuse or misuse.
- 6. In relation to paragraph 1, you dispensed and/or oversaw the dispensing of high-risk prescription only medicines to patients; including, but not limited to, the medicines and quantities outlined in Schedule B; where all or some of these were not suitable to be prescribed solely on the basis of an online questionnaire and/or required ongoing monitoring.
- 7. In relation to paragraph 1, you dispensed and/or had oversight of dispensing to the following patients of the following medicines on these approximate dates:
 - 7.1. Patient 12,
 - 7.1.1. 56 capsules of Pregabalin 75mg on or about 10 February 2018;
 - 7.1.2. 56 capsules of Pregabalin 300mg on or about 14 February 2018, 4 April 2018 and 28 April 2018;
 - 7.1.3. 100 tablets of Dihydrocodeine 30mg on or about 14 February 2018, 4 April 2018, 28 April 2018 and 24 June 2018
 - 7.1.4. 56 tablets of Amitriptyline 25mg on or about 24 June 2018; and/or
 - 7.1.5. 100 tablets of Gabapentin 300mg on or about 8 May 2018
 - 7.2. Patient 6, 14 tablets of Zopiclone 7.5mg on or about 29 May 2018

- 7.3. Patient 8, 84 tablets of Amitriptyline 25mg on or about 8 July 2018
- 7.4. Patient 10, 100 tablets of Dihydrocodeine 30mg on or about 5 August 2018.
8. In relation to all or some of patients in paragraphs 7, you failed to assure yourself that they had been prescribed in accordance with the relevant guidance from the GMC, the RPS and/or GPhC in that they were prescribed in the circumstances outlined in paragraphs 4.1 to 4.6.
9. In relation to Patient 6, you failed to assure yourself that the UK Meds/the Pharmacy had carried out a robust identity check.
10. Between around April 2018 and October 2019 provided pharmacy services at a distance together with MyUKDoctor.co.uk ('MyUKDoctor') including dispensing high-risk medicines such as z-drugs and opiates.
11. In relation to paragraph 10, you entered into a business arrangement and then continued to dispense high-risk medicines prescribed through MyUKDoctor, without carrying out adequate due diligence, and/or assuring yourself at any point prior to the GPhC inspection on 16 October 2019 that:
- 11.1. MyUKDoctor was regulated by a UK regulator and/or the prescriber(s) themselves were appropriately regulated;
- 11.2. The prescriber(s) were prescribing medicines in accordance with and/or paying due regard to the relevant guidance on prescribing from the GMC, RPS and/or GPhC;
- 11.3. The risks associated with the prescribing model were identified and managed, especially in relation to (but not limited to) the:
- 11.3.1. Prescriber(s) being based outside the UK
- 11.3.2. The supply of high-risk medicines; and/or
- 11.3.3. The abuse or misuse of medicines.
- 11.4. There was adequate indemnity insurance in place for the prescriber/s and/or for the pharmacy for the activity being undertaken;
- 11.5. The prescribing model that was used adequately safeguarded patients;

- 11.6. There were appropriate audits in place to ensure safe prescribing;
 - 11.7. The prescribing service had in place a clear privacy policy available on their website;
 - 11.8. The prescribing service had in place a robust identity checking system and/or the prescribers had carried out sufficiently robust identity checks; and/or
 - 11.9. The prescriber(s) had the relevant training and/or competence to prescribe.
12. In relation to paragraph 10, you dispensed and/or oversaw the dispensing of high-risk prescription only medicines in circumstances where you had not assured yourself that they had been prescribed in accordance with the relevant guidance from GMC, RPS, the GPhC and/or good practice in that they were routinely prescribed in circumstances where prescribers:
- 12.1. Failed to obtain adequate information in relation to patients' health in advance of prescribing;
 - 12.2. Relied principally on the information received in an online questionnaire;
 - 12.3. Failed to access and/or attempt to access patients' GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;
 - 12.4. Failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;
 - 12.5. Failed to make a clear record setting out any justification to prescribe, in circumstances where the patient did not have a GP or did not consent to share information;
 - 12.6. Z-drugs were prescribed for more than two weeks without consideration of referral for appropriate therapy;
 - 12.7. Failed to adequately consider the possibility of medication dependence and misuse; and/or
 - 12.8. Failed to refer, or attempt to refer, patients back to their GP for appropriate assessment and/or review and/or monitoring.
13. In relation to paragraph 10, you failed to assure yourself that the Pharmacy had in place a safeguarding policy to protect patients using its pharmacy services including any service in association with MyUKDoctor and/or failed to ensure patients were adequately safeguarded.

14. In relation to paragraph 10, you allowed checks to be carried out by one or more individuals who did not have appropriate training and/or qualification.
15. In relation to paragraph 10, you did not manage the risk that the Pharmacy was incentivised to supply medication, even if it was not clinically appropriate, in that the Pharmacy was only paid for each medication supplied and did not receive any payment when a supply was declined.
16. In relation to paragraph 10, you dispensed and/or oversaw the dispensing of prescriptions in circumstances where patients were dissuaded from providing consent to contact their GP by warning them that it might delay their order.:
17. In relation to paragraph 10, you did not to ensure that the Pharmacy had direct contact with patients and were, where appropriate providing appropriate:
 - 17.1. Advice and/or counselling information
 - 17.2. Detailed advice about their prescribed medication or medical condition and/or
 - 17.3. Signposting and safety netting
18. You repeatedly dispensed/had oversight of some or all of the dispensing of the medicines to Patients, A, B, C and/or D on the dates outlined in Schedule C contrary to GPhC guidance, in that you had not assured yourself:
 - 18.1. That the prescriber had contacted the GP in advance of issuing the prescription;
 - 18.2. That the GP had confirmed that the prescription was appropriate for the patient; and/or
 - 18.3. That appropriate monitoring was in place.
19. In relation to paragraph 10, you failed to identify and manage the risks of dispensing medicines liable to abuse or misuse.

And in light of the above your fitness to practise is impaired by reason of your misconduct.

Schedule A

Patient No & ID	Date(s)	Medicine/Quantity
Patient ID. 1124	31 January 2018	Pregablin 150mg 56 Capsules
	16 March 2018	Pregablin 150mg 56 Capsules

	5 May 2018	Pregablin 150mg 56 Capsules
	22 May 2018	Zolpidem 10mg 14 Tablets
Patient ID. 1607	19 February 2018	Zopiclone 7.5mg 14 Tablets
	13 May 2018	Zopiclone 7.5mg 14 Tablets
	17 June 2018	Zopiclone 7.5mg 14 Tablets
	29 July 2018	Zopiclone 7.5mg 14 Tablets
Patient ID. 1755	12 February 2018	Zopiclone 7.5mg 14 Tablets
	3 June 2018	Zopiclone 7.5mg 14 Tablets Co-codamol 30/500mg 200 Tablets
	3 July 2018	Zopiclone 7.5mg 14 Tablets Co-codamol 30/500mg 200 Tablets
	19 August 2018	Co-codamol 30/500mg 200 Tablets

Patient ID. 1519	17 January 2018	Dihydrocodeine 30mg 200 Tablets
	2 March 2018	Dihydrocodeine 30mg 100 Tablets

	20 March 2018	Dihydrocodeine 30mg 100 Tablets
	29 May 2018	Dihydrocodeine 30mg 100 Tablets
Patient ID. 1235	11 April 2018	Dihydrocodeine 30mg 100 Tablets
	28 April 2018	Dihydrocodeine 30mg 100 Tablets
	6 May 2018	Modafinil 200mg 30 Tablets
	11 May 2018	Dihydrocodeine 30mg 100 Tablets
Patient ID. 1880	7 February 2018	Dihydrocodeine 30mg 28 Tablets
	19 April 2018	Dihydrocodeine 30mg 100 Tablets

	2 May 2018	Dihydrocodeine 30mg 100 Tablets
	11 June 2018	Dihydrocodeine 30mg 100 Tablets
Patient ID. 2690	23 February 2018	Gabapentin 300mg 100 Capsules
	31 March 2018	Co-codamol 30/500mg 200 Tablets
	17 April 2018	Gabapentin 300mg 100 Capsules
	20 May 2018	Gabapentin 300mg 100 Capsules
	16 June 2018	Gabapentin 300mg 100 Capsules
Patient ID. 1407	7 March 2018	Modafinil 200mg 30 Tablets
	4 April 2018	Modafinil 200mg 30 Tablets
	2 May 2018	Modafinil 200mg 30 Tablets
Patient ID. 7744	9 May 2018	Modafinil 100mg 30 Tablets
	8 June 2018	Modafinil 100mg 30 Tablets

Patient ID. 19704	18 April 2018	Amitriptyline 25mg 84 Tablets
	14 May 2018	Amitriptyline 25mg 84 Tablets
	26 July 2018	Amitriptyline 25mg 84 Tablets

Patient ID. 4162	5 March 2018	Amitriptyline 25mg 84 Tablets
	31 March 2018	Amitriptyline 25mg 84 Tablets
	26 April 2018	Kapake 30mg/500mg 84 Tablets Amitriptyline 25mg 84 Tablets
Patient ID. 18505	24 February 2018	Propranolol 10mg 28 Tablets
	26 March 2018	Propranolol 10mg 56 Tablets

	9 September 2018	Propranolol 10mg 56 Tablets
Patient ID. 49416	24 February 2018	Propranolol 10mg 28 Tablets
	6 March 2018	Propranolol 10mg 28 Tablets
	5 May 2018	Propranolol 40mg 56 Tablets
	11 June 2018	Propranolol 40mg 56 Tablets
	5 August 2018	Propranolol 40mg 28 Tablets
	15 August 2018	Propranolol 40mg 28 Tablets
Patient ID. 33260	29 January 2018	Metformin 500mg 168 Tablets
	19 March 2018	Metformin 500mg 168 Tablets
	12 June 2018	Metformin 500mg 168 Tablets
	30 July 2018	Metformin 500mg 168 Tablets
Patient ID. 12951	9 July 2018	Ventolin 1 Inhaler
Patient 6 - 30322	29 May 2018	Zopiclone 7.5 mg 14 Tablets

Patient 8 - 2693	8 July 2018	Amitriptyline 25mg 84 Tablets
Patient 10 - 206117	4 August 2018	Dihydrocodeine 30mg 100 Tablets
Patient 12 - 54446	10 February 2018	Pregabalin 75mg 56 Capsules
	14 February 2018	Dihydrocodeine 30mg 100 Tablets Pregabalin 300mg 56 Capsules

	4 April 2018	Pregabalin 300mg 56 Capsules
	4 April 2018	Dihydrocodeine 30mg 100 Tablets
	28 April 2018	Dihydrocodeine 30mg 100 Tablets

	28 April 2018	Pregabalin 300mg 56 Capsules
	8 May 2018	Gabapentin 300mg 100 Capsules
	24 June 2018	Dihydrocodeine 30mg 100 Tablets Amitriptyline 25mg 56 Tablets
Patient 30 - 2088	04 April 2018	Codeine 30mg 100 Tablets
	30 April 2018	Codeine 30mg 100 Tablets
	05 August 2018	Codeine 30mg 100 Tablets
Patient 31 - 3024	04 July 2018	Codeine 30mg 100 Tablets
	11 August 2018	Codeine 30mg 100 Tablets
Patient 32 - 4162	05 March 2018	Amitriptyline 25mg 84 Tablets
	31 March 2018	Amitriptyline-25mg 84 Tablets Kapake 30mg/500mg 200 Tablets
	26 April 2018	Kapake 30mg/500mg 200 Tablets Amitriptyline 25mg 84 Tablets
Patient 33 - 119413	05 May 2018	Dihydrocodeine 30mg 28 Tablets
	04 June 2018	Co-codamol 30/500mg 100 Tablets

	06 June 2018	Zopiclone 7.5mg 14 Tablets
	17 June 2018	Co-codamol 30/500mg 100 Tablets
	29 June 2018	Co-codamol 30/500mg 100 Tablets
	14 July 2018	Propranolol 40mg 28 Tablets
Patient 34 - 4247	09 February 2018	Codeine 30mg 100 Tablets

	08 August 2018	Codeine 30mg 100 Tablets
Patient 42 - 76478	24 May 2018	Amitriptyline 25mg 28 Tablets
	24 July 2018	Amitriptyline 25mg 28 Tablets
Patient 43 - 434570	18 June 2018	Zimovane 7.5mg 14 Tablets
	18 July 2018	Zimovane 7.5mg 14 Tablets
	21 August 2018	Zopiclone 7.5mg 14 Tablets
Patient 47 - 2202	14 April 2018	Dihydrocodeine 30mg 100 Tablets
	06 September 2018	Dihydrocodeine 30mg 100 Tablets

Schedule B

Date(s)	Medicine	No. dispensed
2 January 2018 - 3 October 2018	Zopiclone	4,035
10 January 2018 - 3 October 2018	Zolpidem	1,305
16 January 2018 - 3 October 2018	Zimovane	1,776
1 January 2018 - 3 October 2018	Dihydrocodeine and Codeine	7,206
9 January 2018 - 3 October 2018	Co-codamol (including Kapake, Solpadol, Zapain)	2,921
9 January 2018 - 3 October 2018	Co-dydramol (including Remedeine)	177
9 January 2018 - 3 October 2018	Gabapentin	359
8 January 2018 - 3 October 2018	Pregabalin	1,270

2 January 2018 - 3 October 2018	Modafinil	2,196
11 January 2018 - 2 October 2018	Amitriptyline	258
17 January 2018 - 1 October 2018	Propranolol	359
31 January 2018 - 20 September 2018	Orlistat	282
12 January 2018 - 2 October 2018	Metformin	335
12 January 2018 - 30 September 2018	Ventolin (Salbutamol)	359

Schedule C

Patient A

Date	Medicines
6 October 2018	Dihydrocodeine 30mg 100 Tablets
6 November 2018	Dihydrocodeine 30mg 100 Tablets
7 December 2018	Dihydrocodeine 30mg 100 Tablets
29 December 2018	Dihydrocodeine 30mg 100 Tablets
22 February 2019	Dihydrocodeine 30mg 100 Tablets
20 March 2019	Dihydrocodeine 30mg 100 Tablets
25 April 2019	Dihydrocodeine 30mg 100 Tablets
22 May 2019	Dihydrocodeine 30mg 100 Tablets
12 June 2019	Dihydrocodeine 30mg 100 Tablets
9 July 2019	Dihydrocodeine 30mg 100 Tablets
2 August 2019	Dihydrocodeine 30mg 100 Tablets
29 August 2019	Dihydrocodeine 30mg 100 Tablets
23 September 2019	Dihydrocodeine 30mg 100 Tablets
15 October 2019	Dihydrocodeine 30mg 100 Tablets

Patient B

Date	Medicines
2 January 2019	Zapain 30/500mg 100 Caplets
23 January 2019	Zapain 30/500mg 100 Caplets
18 February 2019	Zapain 30/500mg 100 Caplets

Patient C

Date	Medicines
8 February 2019	Zopiclone 7.5mg 14 Tablets
3 April 2019	Zopiclone 7.5mg 14 Tablets
2 May 2019	Zopiclone 7.5mg 14 Tablets
6 June 2019	Zopiclone 7.5mg 14 Tablets
15 July 2019	Zopiclone 7.5mg 14 Tablets
17 September 2019	Zopiclone 7.5mg 14 Tablets
15 October 2019	Zopiclone 7.5mg 14 Tablets

Patient D

Date	Medicines
27 March 2019	Solpadol 30/500mg 200 Caplets
5 June 2019	Solpadol 30/500mg 200 Caplets
25 September 2019	Solpadol 30/500mg 100 Caplets
15 October 2019	Zapain 30/500mg 200 Caplets

You, a registered pharmacist, while acting as a Superintendent Pharmacist ('SI') of JIT Laboratories Ltd (t/a Homecare Pharmacy, ('the Pharmacy'),

1. At all times as SI, it was your duty as SI to manage the dispensing of all medicinal products other than those on a general sales list.
2. Between around 3 August 2018 and 3 October 2018 as SI, you managed the provision of pharmacy services at a distance, including the supply of prescription only medicines, that had been prescribed through UK Meds Direct Ltd ('UK Meds').
3. In relation to paragraph 2, you managed and/or had oversight of a dispensing model that dispensed approximately 6,903 prescriptions including approximately 4,964 for high-risk medicines.
4. In relation to paragraph 2, you managed and/or oversaw a dispensing model that dispensed high-risk medicines which had been prescribed without due consideration of the relevant guidance from the General Medical Council ('GMC'), the Royal Pharmaceutical Society ('RPS') and/or the General Pharmaceutical Council ('GPhC') in that they were routinely prescribed in circumstances where the prescriber had:
 - 4.1. Failed to obtain adequate information in relation to patients' health in advance of prescribing;
 - 4.2. Relied principally on the information received in an online questionnaire;
 - 4.3. Failed to access and/or attempt to access patients' GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

- 4.4. Failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;
- 4.5. Failed to adequately consider the possibility of medication dependence and misuse;
- 4.6. Failed to refer, or attempt to refer, patients back to their GP for appropriate assessment and/or review and/or monitoring.
5. In relation to paragraph 2, you failed to adequately mitigate the risks of medicine abuse or misuse in that you managed and/or oversaw the prescription dispensing model that allowed high-risk prescriptions to be repeatedly dispensed to patients who had already made repeated orders for the same medicine or same type of medicine from UK Meds, including, but not limited to, all or some of the patients and medicines outlined in Schedule A.
6. In relation to paragraph 2, you managed and/or oversaw a prescription dispensing model that allowed the dispensing of high-risk prescriptions to patients; including, but not limited to, the medicines and quantities outlined in Schedule B; where all or some of these, were not suitable to be prescribed solely on the basis of an online questionnaire and/or required ongoing monitoring.
7. Between around August 2018 and October 2019 as SI for the Pharmacy, you managed the provision of pharmacy services at a distance, including the supply/dispensing of prescription only medicines, that had been prescribed through MyUKDoctor.co.uk ('MyUKDoctor').
8. In relation to paragraph 7 you managed a prescription dispensing model and/or oversaw the dispensing of high-risk medicines, without carrying out yourself or, in the alternative, assuring yourself, that due diligence had been carried out by others, including that:
 - 8.1. MyUKDoctor was regulated by a UK regulator and/or the prescriber(s) themselves were appropriately regulated;
 - 8.2. The prescriber(s) were prescribing medicines in accordance with and/or pay due regard to the relevant guidance on prescribing from the GMC, RPS and/or GPhC;
 - 8.3. The risks associated with the prescribing model were identified and managed, especially in relation to (but not limited to) the:
 - 8.3.1. Prescriber(s) being based overseas; and/or
 - 8.3.2. A large number of medicines being prescribed were liable to misuse or abuse.

- 8.4. There was adequate indemnity insurance in place for the prescriber/s and/or for the pharmacy for the activity being undertaken;
 - 8.5. The prescribing model that was used adequately safeguarded patients;
 - 8.6. There were appropriate audits in place to ensure safe prescribing;
 - 8.7. The prescribing service had in place a clear privacy policy available on their website;
 - 8.8. The prescribing service had in place a robust identity checking system and/or the prescribers had carried out sufficiently robust identity checks; and/or
 - 8.9. That the prescribers had the relevant training and/or competence to prescribe.
9. In relation to paragraph 7, you managed a prescription dispensing model and/or oversaw the dispensing of high-risk prescription only medicines in circumstances where you had not assured yourself that they had been prescribed in accordance with the relevant guidance from GMC, RPS, the GPhC and/or good practice in that they were routinely prescribed in circumstances where prescribers:
- 9.1. Failed to obtain adequate information in relation to patients' health in advance of prescribing;
 - 9.2. Relied principally on the information received in an online questionnaire;
 - 9.3. Failed to access and/or attempt to access patients' GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;
 - 9.4. Failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;
 - 9.5. Failed to make a clear record setting out any justification to prescribe, in circumstances where the patient did not have a GP or did not consent to share information;
 - 9.6. Z-drugs were prescribed for more than two weeks without consideration of referral for appropriate therapy;
 - 9.7. Failed to adequately consider the possibility of medication dependence and misuse; and/or

- 9.8. Failed to refer, or attempt to refer, patients back to their GP for appropriate assessment and/or review and/or monitoring.
10. In relation to paragraph 7, you managed a prescription dispensing model and/or oversaw the dispensing of high-risk medicines without ensuring that the Pharmacy had in place an adequate safeguarding policy to protect patients using the pharmacy services including any in association with MyUKDoctor.co.uk and/or failed to ensure that patients were adequately safeguarded.
11. In relation to paragraph 7, you managed a prescription dispensing model without effectively managing the risk that the Pharmacy was incentivised to supply medication, even if it was not clinically appropriate, in that the Pharmacy was only paid for each medication supplied and did not receive any payment when a supply was declined.
12. In relation to paragraph 7, you managed a prescription dispensing model in circumstances where patients were dissuaded from providing consent to contact their GP by warning them that it might delay their order.
13. In relation to paragraph 7, you managed a prescription dispensing model in circumstances, where you had not ensured that the services had been adequately risk assessed including the risks associated with:
- 13.1. Working with prescriber(s) based outside the UK;
- 13.2. The supply of high-risk medicines; and/or
- 13.3. The abuse or misuse of medicines.
14. In relation to paragraphs 2 and 7, you failed to have in place adequate Standard Operating Procedures to adequately mitigate the risks associated with the supply of high-risk medicines at a distance.

And in light of the above your fitness to practise is impaired by reason of your misconduct.

Schedule A

Patient No. & ID	Date(s)	Medicine/Quantity
Patient ID. 7409	22 September 2018	Zopiclone 7.5mg 14 Tablets
Patient ID. 8772	16 September 2018	Zopiclone 7.5mg 7 Tablets
	30 September 2018	Zopiclone 7.5mg 7 Tablets
Patient ID. 1881	25 August 2018	Dihydrocodeine 30mg 100 Tablets

Patient ID. 5839	13 August 2018	Dihydrocodeine 30mg 100 Tablets
Patient ID. 14700	30 August 2018	Gabapentin 300mg 100 Capsules
	23 September 2018	Gabapentin 300mg 100 Capsules
Patient ID. 26760	30 September 2018	Modafinil 100mg 30 Tablets
Patient ID. 16430	26 August 2018	Modafinil 200mg 30 Tablets
Patient ID. 8314	4 September 2018	Amitriptyline 25mg 84 Tablets
Patient ID. 18505	9 September 2018	Propranolol 10mg 56 Tablets
Patient ID. 49416	5 August 2018	Propranolol 40mg 28 Tablets
	15 August 2018	Propranolol 40mg 28 Tablets

Patient 10 - 206117	5 August 2018	Dihydrocodeine 30mg 100 Tablets
Patient 30 - 2088	05 August 2018	Codeine 30mg 100 Tablets

Patient 31 - 3024	11 August 2018	Codeine 30mg 100 Tablets
Patient 34 - 4247	08 August 2018	Codeine 30mg 100 Tablets
Patient 43 - 434570	21 August 2018	Zopiclone 7.5mg 14 Tablets
Patient 46 - 142391	24 August 2018	Metformin 500mg 168 Tablets
Patient 47 - 2202	06 September 2018	Dihydrocodeine 30mg 100 Tablets

Schedule B

Date(s)	Medicine	No. dispensed
3 August 2018 - 1 October 2018	Zopiclone	964
3 August 2018 – 3 October 2018	Zolpidem	329
3 August 2018 – 3 October 2018	Zimovane	395
3 August 2018 – 3 October 2018	Dihydrocodeine and Codeine	1,545
3 August 2018 – 3 October 2018	Co-codamol (including Kapake, Solpadol, Zapain)	679
30 August 2018 – 3 October 2018	Co-dydramol (including Remedeine)	37
3 August 2018 – 3 October 2018	Gabapentin	82
3 August 2018 – 3 October 2018	Pregabalin	232
3 August 2018 – 3 October 2018	Modafinil	353
3 August 2018 – 3 October 2018	Amitriptyline	59
3 August 2018 – 3 October 2018	Propranolol	126
3 August 2018 – 3 October 2018	Orlistat	135
3 August 2018 – 3 October 2018	Metformin	113
3 August 2018 – 3 October 2018	Ventolin (Salbutamol)	116

Sonia Aggarwal

You, a registered pharmacist, while acting as a Superintendent Pharmacist ('SI') of JIT Laboratories Ltd (t/a Homecare Pharmacy, ('the Pharmacy'),

1. At all times as SI, it was your duty as SI to manage the dispensing of all medicinal products other than those on a general sales list.
2. Between 30 December 2017 and 2 August 2018, you managed the provision of pharmacy services at a distance that had been prescribed through UK Meds Direct Ltd ('UK Meds') that dispensed approximately 21,207 prescriptions to patients, including approximately 17,312 prescriptions for high-risk medicines.
3. In relation to paragraph 2, you managed and/or had oversight of a prescription dispensing model that dispensed high-risk medicines, without carrying out yourself or, in the alternative, assuring yourself, that adequate due diligence had been carried out by others including that the risks associated with the prescribing model were identified and managed.
4. In relation to paragraph 2, you managed and/or oversaw a dispensing model that dispensed high-risk medicines which had been prescribed without due consideration of the relevant guidance from the General Medical Council ('GMC'), the Royal Pharmaceutical Society ('RPS') and/or the General Pharmaceutical Council ('GPhC') in that they were routinely prescribed in circumstances where the prescriber had:
 - 4.1. Failed to obtain adequate information in relation to patients' health in advance of prescribing;
 - 4.2. Relied principally on the information received in an online questionnaire;

- 4.3. Failed to access and/or attempt to access patients' GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;
- 4.4. Failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;
- 4.5. Failed to adequately consider the possibility of medication dependence and misuse;
- 4.6. Failed to refer, or attempt to refer, patients back to their GP for appropriate assessment and/or review and/or monitoring; and/or
5. In relation to paragraph 2, you failed to adequately mitigate the risks of medicine abuse or misuse in that you managed and/or oversaw the prescription dispensing model that allowed high-risk prescriptions to be repeatedly dispensed to patients who had already made repeated orders for the same medicine or same type of medicines from UK Meds, including, but not limited to, all or some of the patients and medicines outlined in Schedule A.
6. In relation to paragraph 2, you managed and/or oversaw the prescription dispensing model that allowed the dispensing of high-risk prescriptions to patients; including, but not limited to, the medicines and quantities outlined in Schedule B; where all or some of these were not suitable to be prescribed solely on the basis of an online questionnaire and/or required ongoing monitoring.
7. In relation to paragraph 2, you managed and/or oversaw the dispensing model that dispensed all or some of the the medicines outlined in Schedule C to the patients and on the occasions outlined in that schedule.
8. In relation to paragraph 2, you managed the dispensing model that supplied all or some of the medicines in Schedule C, to the patients identified in that schedule, when they had been prescribed without due consideration of the relevant guidance from the GMC, the RPS and/or GPhC and had been routinely prescribed in circumstances identified in paragraph 4.1 to 4.6.
9. In relation to paragraph 2, you failed to have in place adequate Standard Operating Procedures to adequately mitigate the risks associated with the supply of high-risk medicines at a distance.

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

Schedule A

Patient No & ID	Date(s)	Medicine/Quantity
Patient ID. 1124	31 January 2018	Pregablin 150mg 56 Capsules

	16 March 2018	Pregablin 150mg 56 Capsules
	5 March 2018	Pregablin 150mg 56 Capsules
	22 May 2018	Zolpidem 10mg 14 Tablets
Patient ID. 1607	19 February 2018	Zopiclone 7.5mg 14 Tablets
	13 May 2018	Zopiclone 7.5mg 14 Tablets
	17 June 2018	Zopiclone 7.5mg 14 Tablets
	29 July 2018	Zopiclone 7.5mg 14 Tablets
Patient ID. 1755	12 February 2018	Zopiclone 7.5mg 14 Tablets
	3 June 2018	Zopiclone 7.5mg 14 Tablets Co-codamol 30/500mg 200 Tablets
	3 July 2018	Zopiclone 7.5mg 14 Tablets Co-codamol 30/500mg 200 Tablets
Patient ID. 1519	2 March 2018	Dihydrocodeine 30mg 100 Tablets

	20 March 2018	Dihydrocodeine 30mg 100 Tablets
	29 May 2018	Dihydrocodeine 30mg 100 Tablets

Patient ID. 1235	11 April 2018	Dihydrocodeine 30mg 100 Tablets
	28 April 2018	Dihydrocodeine 30mg 100 Tablets
	6 May 2018	Modafinil 200mg 30 Tablets
	11 May 2018	Dihydrocodeine 30mg 100 Tablets
Patient ID. 1880	7 February 2018	Dihydrocodeine 30mg 28 Tablets
	19 April 2018	Dihydrocodeine 30mg 100 Tablets
	2 May 2018	Dihydrocodeine 30mg 100 Tablets

	11 June 2018	Dihydrocodeine 30mg 100 Tablets
Patient ID. 2690	23 February 2018	Gabapentin 300mg 100 Capsules
	31 March 2018	Co-codamol 30/500mg 200 Capsules
	17 April 2018	Gabapentin 300mg 100 Capsules
	20 May 2018	Gabapentin 300mg 100 Capsules
	16 June 2018	Gabapentin 300mg 100 Capsules
Patient ID. 1407	7 March 2018	Modafinil 200mg 30 Tablets
	4 April 2018	Modafinil 200mg 30 Tablets
	2 May 2018	Modafinil 200mg 30 Tablets
Patient ID. 7744	9 May 2018	Modafinil 100mg 30 Tablets
	8 June 2018	Modafinil 100mg 30 Tablets
Patient ID. 19704	18 April 2018	Amitriptyline 25mg 84 Tablets
	14 May 2018	Amitriptyline 25mg 84 Tablets

	26 July 2018	Amitriptyline 25mg 84 Tablets
Patient ID. 4162	5 March 2018	Amitriptyline 25mg 84 Tablets
	31 March 2018	Amitriptyline 25mg 84 Tablets

	26 April 2018	Kapake 30mg/500mg 200 Tablets Amitriptyline 25mg 84 Tablets
Patient ID. 18505	24 February 2018	Propranolol 10mg 28 Tablets
	26 March 2018	Propranolol 10mg 56 Tablets
Patient ID. 49416	24 February 2018	Propranolol 10mg 28 Tablets

	6 March 2018	Propranolol 10mg 28 Tablets
	5 May 2018	Propranolol 10mg 56 Tablets
	11 June 2018	Propranolol 10mg 56 Tablets
Patient ID. 33260	19 March 2018	Metformin 500mg 168 Tablets
	12 June 2018	Metformin 500mg 168 Tablets
	30 July 2018	Metformin 500mg 168 Tablets
Patient ID. 12951	9 July 2018	Ventolin 1 Inhaler
Patient 6 - 30322	29 May 2018	Zopiclone 7.5 mg 14 Tablets
Patient 8 - 2693	8 July 2018	Amitriptyline 25mg 84 Tablets
Patient 10 - 206117	4 August 2018	Dihydrocodeine 30mg 100 Tablets
Patient 12 - 54446	10 February 2018	Pregabalin 75mg 56 Capsules
	14 February 2018	Dihydrocodeine 30mg 100 Tablets Pregabalin 300mg 56 Capsules
	4 April 2018	Pregabalin 300mg 56 Capsules
	4 April 2018	Dihydrocodeine 30mg 100 Tablets

	28 April 2018	Dihydrocodeine 30mg 100 Tablets
	28 April 2018	Pregabalin 300mg 56 Capsules
	8 May 2018	Gabapentin 300mg 100 Capsules
	24 June 2018	Dihydrocodeine 30mg 100 Tablets

		Amitriptyline 25mg 56 Tablets
Patient 30 - 2088	4 April 2018	Codeine 30mg 100 Tablets
Patient 31 - 3024	04 July 2018	Codeine 30mg 100 Tablets

Patient 32 - 4162	05 March 2018	Amitriptyline 25mg 84 Tablets
	31 March 2018	Amitriptyline-25mg 84 Tablets Kapake 30mg/500mg 200 Tablets
	26 April 2018	Kapake 30mg/500mg 200 Tablets Amitriptyline 25mg 84 Tablets
Patient 33 -119413	05 May 2018	Dihydrocodeine 30mg 28 Tablets
	04 June 2018	Co-codamol 30/500mg 100 Tablets
	06 June 2018	Zopiclone 7.5mg 14 Tablets
	17 June 2018	Co-codamol 30/500mg 100 Tablets
	29 June 2018	Co-codamol 30/500mg 100 Tablets
	14 July 2018	Propranolol 40mg 28 Tablets
Patient 34 - 4247	09 February 2018	Codeine 30mg 100 Tablets
Patient 42 - 76478	24 May 2018	Amitriptyline 25mg 28 Tablets
	24 July 2018	Amitriptyline 25mg 28 Tablets
Patient 43 - 434570	18 June 2018	Zimovane 7.5mg 14 Tablets
	18 July 2018	Zimovane 7.5mg 14 Tablets

Patient 47 - 2202	14 April 2018	Dihydrocodeine 30mg 100 Tablets
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Schedule B

Date(s)	Medicine	No. dispensed
2 January 2018 - 2 August 2018	Zopiclone	3,074
2 January 2018 - 2 August 2018	Zolpidem	976
2 January 2018 - 2 August 2018	Zimovane	1,381
1 January 2018 - 2 August 2018	Dihydrocodeine and Codeine	5,664
1 January 2018 - 2 August 2018	Co-codamol (including Kapake, Solpadol, Zapain)	2,244
1 January 2018 - 2 August 2018	Co-dydramol (including Remedeine)	141
8 January 2018 - 1 August 2018	Gabapentin	277
8 January 2018 - 1 August 2018	Pregabalin	1,038
2 January 2018 - 2 August 2018	Modafinil	1,844
11 January 2018 – 2 August 2018	Amitriptyline	199
17 January 2018 - 2 August 2018	Propranolol	234
31 January 2018 - 2 August 2018	Orlistat	148
12 January 2018 - 2 August 2018	Metformin	226
12 January 2018 - 2 August 2018	Ventolin (Salbutamol)	242

Schedule C

Patient No.	Date(s)	Medicine/Quantity
Patient 6	29 May 2018	Zopiclone 7.5mg 14 Tablets
Patient 8	8 July 2018	Amitriptyline 25mg 84 Tablets

Patient 10	5 August 2018	Dihydrocodeine 30mg 100 Tablets
Patient 12	10 February 2018	Pregabalin 300mg 56 Capsules
	14 February 2018	Dihydrocodeine 30mg 100 Tablets Pregabalin 300mg 56 Capsules
	4 April 2018	Dihydrocodeine 30mg 100 Tablets Pregabalin 300mg 56 Capsules
	28 April 2018	Dihydrocodeine 30mg 100 Tablets Pregabalin 300mg 56 Capsules
	8 May 2018	Gabapentin 300mg 100 Tablets
	24 June 2018	Dihydrocodeine 30mg 100 Tablets Amitriptyline 25mg 56 Tablets

Documentation

Document No.	Description
1	GPhC main bundle of 1474 pages
2	GPhC statement of case and skeleton argument of 44 pages
3	Amarjit Bassi – statement of 5 pages
4	Amarjit Bassi – letter to FtP Committee of 2 pages
5	Amarjit Bassi – proof of service bundle of 6 pages
6	DEFENCE STATEMENT OF CASE AND SKELETON ARGUMENT ON BEHALF OF MA AND SA ONLY of 11 pages
7	Mukesh Aggarwal - statement and bundle of 238 pages
8	Sonia Aggarwal - statement and bundle of 434 pages
9	Sonia Aggarwal – statement of 25 pages
10	Sonia Aggarwal – remediation bundle of 378 pages

11	Sonia Aggarwal – testimonial bundle of 31 pages
12	Proceeding in absence (PIA) bundle (re AB) of 22 pages
13	Pharmacy insurance bundle (8 files)
14	Handwritten notes of SJ of 4 pages

Witnesses

1. Dr C
2. Ms NH
3. Ms S
4. Mr SO
5. Ms AM
6. Mr Mukesh Aggarwal
7. Mrs Sonia Aggarwal

Preliminary Matters

On day one, at the start of the hearing, Mr Hoskins applied to adjourn the hearing by one-day. Mr Hoskins submitted that this matter was one of many related matters concerning the same company. In another related hearing, issues had arisen which could affect the reliability of prescribing data. Mr Haycroft did not object to the adjournment but rather welcomed it. The Committee bore in mind Rule 37 of *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010* ('the Rules'). It was noted that no injustice was caused to any party and that it was in the interest of justice to adjourn for this reason. Therefore, the matter was adjourned to reconvene on 21 April 2026.

Determination

Introduction

1. This is the written determination of the Fitness to Practise Committee at the General Pharmaceutical Council ('the Council').
2. This hearing is governed by *The Pharmacy Order 2010* ('the Order') and *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010* ('the Rules').
3. The statutory overarching objectives for these regulatory proceedings are:
 - a. To protect, promote and maintain the health, safety and well-being of the public;
 - b. To promote and maintain public confidence in the professions regulated by the Council; and
 - c. To promote and maintain proper professional standards and conduct for members of those professions.
4. The Committee also has regard to the guidance contained in the Council's *Good decision making: Fitness to practise hearings and outcomes guidance* as revised March 2024.
5. A Principal Hearing has up to three stages:
 - Stage 1. Findings of Fact – the Committee determines any disputed facts.
 - Stage 2. Findings of ground(s) of impairment and impairment – the Committee determines whether, on the facts as proved, a statutory ground for impairment is established and, if so, whether the Registrant's fitness to practise is currently impaired.
 - Stage 3. Outcome – the Committee considers what, if any, outcome should be applied if the Registrant's fitness to practise is found to be impaired.

Service of Notice of Hearing

6. The Committee has seen a Notice of Hearing addressed to Mr Bassi, dated 11 March 2026 sent by email. This email also copied in a representative of Mr Bassi and sent to their registered email address as noted on the Register. Mr Hoskins also submitted that there was evidence that this email had been opened by the recipients.
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.

Proceeding in Absence

8. Mr Hoskins went on to submit that there was a duty upon Mr Bassi to engage with these proceedings. Mr Hoskins also highlighted that there was a public interest to proceed in Mr Bassi's absence. Witnesses were due to attend to give evidence. Mr Hoskins also submitted that Mr Bassi's absence was deliberate and voluntary. Mr Bassi had served a bundle and did not, in the body of this bundle, request an adjournment. Thus, it was the Council's position that an adjournment would not secure Mr Bassi's attendance. Mr Hoskins submitted that it would be inappropriate to sever the matter.
9. Mr Haycroft submitted that this matter had been joined and it was for the Committee to determine whether to sever or to proceed in Mr Bassi's absence. Mr Haycroft submitted that Mr Bassi's evidence did not affect Mrs Aggarwal but did impact upon Mr Aggarwal. The evidence of Mr Bassi was not accepted. Mr Haycroft submitted that should the matter proceed with Mr Bassi in absence, his evidence would be entirely hearsay.
10. The Committee went on to consider if the matter should proceed in the absence of Mr Bassi pursuant to Rule 25 of the Rules. The Committee reminded itself of the principles governing proceeding in absence which derive from R v Jones [2002] UKHL 5. The Committee bore in mind that the discretion to proceed is constrained. It is important to balance the impact upon the Registrant and also the public interest. The Committee considered the case of General Medical Council v Adeogba [2016] EWCA Civ 162 and the differences between regulatory proceedings and criminal proceedings.
11. The Committee noted the following:

- a. Mr Bassi had voluntarily absented himself from these proceedings. Mr Bassi had previously been represented by solicitors and had chosen to not fund representation for the purposes of this hearing.
 - b. It was not believed that an adjournment would serve to secure Mr Bassi's future attendance.
 - c. Mr Bassi would be disadvantaged. However, the Committee had received written evidence from Mr Bassi, albeit evidence that could not be subjected to cross-examination.
 - d. This matter was of some age, and there was a public interest in dealing with the matter expeditiously.
12. The Committee therefore considered it would be appropriate to proceed in Mr Bassi's absence.

Amendment of Allegations

13. Mr Hoskins applied to amend the allegations. The amendments pertained to particulars 4.6 for all Registrants, 12.8 for Mr Aggarwal and 9.8 for Mr Bassi. The amendments had been proposed by Mr Haycroft. The amendments sought to insert the words "*or attempt to refer*" to the allegations.
14. Mr Hoskins also sought to amend typographical errors within the schedules concerning the number of tablets prescribed to patients.
15. Mr Hoskins noted a typographical error at 11.1 for Mr Aggarwal and 8.1 for Mr Bassi, which should read "*appropriately*."
16. The Committee noted that it may amend allegations pursuant to Rule 41 of the Rules. It was noted that the proposed amendments did not make the allegations stricter. The amendments to the schedules make them reflect a more accurate position.
17. The Committee considered that no prejudice was caused to any Registrant, including Mr Bassi. Therefore the Committee was content to allow the amendments sought.
18. On 27 April, Mr Hoskins applied to amend the allegations as follows:
 - a. Mr Bassi's allegation 3, the approximate figure of 5,165 high risk medications was incorrect. In light of AM's evidence, the more accurate figure was 4,964.

- b. Mrs Aggarwal's allegation 2, subsequent to AM's evidence, her witness statement had been updated, but the allegations had not. The correct figure for high-risk medications was not 17,688 but rather 17,312.
- 19. Mr Hoskins submitted that in the absence of Mr Bassi, it would be appropriate to amend the allegations to reflect the most accurate picture available. Mr Hoskins sought for Mrs Aggarwal's admission to the original allegation 2 be re-opened in order to allow for the admission to properly reflect the evidence.
- 20. Mr Haycroft did not object and indicated that Mrs Aggarwal would admit the amended allegation.
- 21. The Committee rehearsed the guidance applied above. It was noted that no prejudice was caused to parties. It was deemed to be in the interests of justice for the allegations to be as accurate as possible. The overriding objective of fairness was best served by amendments to the relevant particulars.
- 22. In all the circumstances, the Committee exercised its case management powers to allow for the re-opening of Mrs Aggarwal's admission to the unamended allegation 2 as submitted by Mr Hoskins and accepted by Mr Haycroft.
- 23. Mr Hoskins applied to amend allegation 9.6 in respect of Mr Bassi. Mr Hoskins submitted that the evidence suggested that Z-drugs were prescribed for more than four weeks as opposed to the "*more than two weeks*" as originally drafted in the allegations.
- 24. The Committee considered this to be a simple error in drafting that caused Mr Bassi no prejudice in the circumstances. Thus, the amendment was minded to allow the amendment as applied for.

Registrants' response to Particulars of allegation

- 25. Mr Aggarwal admitted the following allegations:
 - a. 1 – 10 (in entirety),
 - b. 11.2 – 11.9
 - c. 12 -13 and 16-19 (in entirety).
- 26. Mr Aggarwal did not admit allegations 11.1, 14 and 15.

27. Mrs Aggarwal admitted allegations 1-9 (in entirety).
28. Mr Bassi did not admit any of the allegations (1-14).
29. In the light of the above, and by the application of Rule 31(6) of the Rules, the admitted factual particulars were found proved.
30. The Committee went on to receive evidence and submissions regarding the disputed particulars.

Application to Offer No Evidence

31. Having fully opened the Council's case, Mr Hoskins sought to offer no evidence with regards to allegations 5 and 7, faced by Mrs Aggarwal alone. The application was limited to the facts pertaining to Patient 10. This patient appeared in both Schedules A and C pertaining to Mrs Aggarwal. Patient 10 fell outside of the relevant date range, i.e. 30 December 2017 – 2 August 2018, at which Mrs Aggarwal was acting as SI. Furthermore, Mr Bassi had given evidence, in the form of a letter from his representatives, that he had taken on the position of SI from 3 August 2018 onwards. The dates for which Patient 10 appeared in Mrs Aggarwal's schedules was 4 August 2018 (Schedule A) and 5 August 2018 (Schedule C). However, it was further noted that the date of 4 August 2018 was itself, erroneous, and should have read 5 August 2018.
32. The Committee bore in mind the relevant guidance from the High Court in the case of Professional Standards for Health and Social Care v Nursing and Midwifery Council and X [2018] EWHC 70 (Admin). The appropriate procedure was for Mr Hoskins to fully open and then make his application.
33. The Committee considered that the application pertained purely to Patient 10 as outlined above. The Committee was content to allow Mr Hoskins' application to offer no evidence in this regard.

34. Accordingly, Schedule A for Mr Aggarwal was amended to 5 August 2018 in relation to Patient 10 to properly reflect the relevant dates.

Background

35. According to the oral evidence given by Mr Aggarwal during the hearing, he was the responsible pharmacist ('RP') and legal owner of Homecare and held directorships of other corporate entities (JIT and/or 8PM Chemist Ltd) which owned Homecare. He stated that he ceased to be the legal owner of Homecare on 31 March 2019. The role of the RP at the time was to secure the safe and effective day-to-day running of Homecare at the time when he was working. It was his responsibility to ensure that the systems were applied safely at the point of him making dispensing decisions. If he was unable to satisfy himself of this, he should have refused to dispense the private prescriptions written by UK Meds of MyUKDoctor. As a director of JIT and, consequently, Homecare, his obligations were broader than simply the day-to-day running of Homecare. They extended to ensuring the quality of the systems, processes and clinical governance of Homecare alongside the SI.
36. At the time of the allegations, Mr Aggarwal was an experienced and competent practitioner. He qualified in 1991. From 2008, Mr Aggarwal worked as the RP at Homecare. In terms of remuneration, Mr Aggarwal was remunerated for contracted hours with 8PM Chemists Ltd as RP. This was the case regardless of the number of prescriptions fulfilled.
37. Subsequent to the cessation of Homecare's dispensing of private prescriptions in or around October 2019 and the imposition of Conditions upon the pharmacy, Mr Aggarwal has been working part-time for 8PM Chemist Ltd and another entity, Medical Centre Pharmacy, which are both community pharmacies.
38. Mrs Aggarwal, who is the sister-in-law of Mr Aggarwal, was the superintendent pharmacist ('SI') at Homecare from 30 December 2017 until 2 August 2018. As the SI, Mrs Aggarwal was required to be responsible for the overall management of Homecare so far as it was related to the sale and supply of medicines. She therefore had leadership responsibility to ensure the premises, systems and processes were safe, for example in ensuring compliance with relevant regulatory standard, the quality and content of Standard Operating Procedures ('SOPs') and governance structures over and above the day-to-day or specific individual supplies of medication.

39. Mrs Aggarwal was an experienced and competent practitioner at the relevant times. She first registered in 1995. She took up the SI position at Homecare at the request of Mr Aggarwal. She left her role as SI, having obtained a Pharmacist Independent Prescriber ('PIP') qualification on 2 August 2018. Since October 2022, she has worked exclusively as a manager at Medical Centre Pharmacy, which is the same company that Mr Aggarwal currently works for.
40. Mr Bassi replaced Mrs Aggarwal at Homecare as the SI on 3 August 2018 and held the post until Homecare effectively ceased dispensing activity for online private prescriptions on or around 17 October 2019. His role as SI was the same as that outlined for Mrs Aggarwal, above.
41. At the time of joining Homecare, Mr Bassi was an experienced and competent practitioner. He qualified in 1980. He worked at 8PM Chemists Ltd for over 25 years as an employee.
42. Whilst acting as SI at Homecare, Mr Bassi continued to work for 2 days/week at 8PM Chemists as an RP. Following the Council's intervention into Homecare, Mr Bassi resigned as SI around 2021. He continued his role at 8PM Chemists until he retired in December 2022.
43. UK Meds was incorporated in 2016 and operated as an online pharmacy that was registered with the Council between 3 August 2017 and 6 September 2021. It had two different physical addresses in Nottingham. Around February 2019 it moved premises.
44. UK Meds operated 7 days/week and dispensed 300 prescriptions daily in February 2018, before growing to 750 prescriptions per day by May 2019, with the majority of the prescriptions being opiates, z-drugs, erectile dysfunction treatments and modafinil.
45. In order to obtain prescriptions, patients would access the relevant website and self-select the desired medications. Patients would then fill in an online questionnaire. The questionnaire would then be considered by a prescriber, who would (generally) work remotely. The prescribers were supervised and monitored by the Clinical Lead ('CL'), Dr Dorina Ambroze. Dr Ambroze would also issue prescriptions in addition to discharging her supervisory function.

46. Initially, whilst working with Homecare, prescribers were a team of GMC registered doctors or doctors engaged by a foreign entity based in Romania, EU GP SARL. From 30 June 2019 (when Homecare no longer dispensed for UK Meds), the totality of the prescribing decisions was made by contracted in-house PIPs.
47. There was little, if any, input with patients' GPs either before or after the prescribing decisions for monitoring purposes. UK Meds only trialled such a process from 2021. On occasions when follow up with patients occurred, this would be conducted by email or telephone, with the prescribers.
48. Once a prescription was issued by a prescriber, it would be dispensed by the in-house pharmacy team within UK Meds' physical premises in Nottingham by post or courier and, where there was insufficient capacity, prescriptions were dispensed by third-party dispensing pharmacists. When dispensing in-house, there was supervision of this function by an RP who, in practice, was also the SI and worked with a team of three full-time dispensers. Queries could be raised by the SI with the CL.
49. UK Meds was subject to a number of inspections by the Council and, in one such inspection dated 15 February 2018, was found to be satisfactory in its in-house dispensing functions. The primary focus of the inspection was the dispensing function in-house at UK Meds and Homecare was, effectively, subcontracted to complete in parallel. Despite the satisfactory finding, red flags were identified as a result of this inspection, including:
- a. the emphasis placed on the CL to speak to patients without the knowledge of the pharmacy team,
 - b. supplies of modafinil to student campuses at times of peak study (e.g. exam times); and
 - c. UK Meds dispensers declined to supply pregabalin and gabapentin (after their reclassification), however, requests were signposted to other pharmacy providers.
50. The SI at UK Meds who took up post weeks prior to the inspection raised concerns about opiate supplies and z-drugs. These concerns were not mirrored by the Registrants in this matter.

51. On or around 2018, UK Meds' prescriptions ceased to be supplied by Homecare. Eventually, after further inspections and concerns, UK Meds was voluntarily removed from the Register on 7 September 2021.
52. The Registrants also worked with MyUKDoctor. This website was used by patients to obtain prescriptions. The owner of the website was a company Index Medical Services Limited ('IMSL'). The website itself was developed and maintained by a company called Kalexiko. The Registrants appeared to interact exclusively with this latter company. Mr Aggarwal appeared to be pivotal to the business arrangements rather than merely developing the website.
53. Prescribing decisions at MyUKDoctor were made by Dr Sidharth Gupta, who operated from Romania. Dr Gupta did not hold GMC registration. He had practised in Ireland from 2014-2016, with specialisms in plastic surgery, sports injuries and orthopaedics. Dr Gupta did hold indemnity insurance, obtained for 2018-19, however, the cap of €62,000 was inadequate by UK Standards.
54. Patients would access the website and provide identification information. There was no automatic system to facilitate ID checks. Mr Aggarwal made the decision not to interact with external entities to conduct ID checks on the basis that he felt that an in-house check comparing a scan or photo of an ID document and billing address was sufficient.
55. Patients would self-select their desired medication (mostly opiates and z-drugs) prior to filling out the questionnaire, rather than it being selected on the basis of their answers to clinical questions. Much like UK Meds, patients would fill in an online questionnaire. It is unclear who reviewed or drafted the content of the questionnaires. When patients answered questions such as to render them unsuitable for the medication, they would be informed by way of a pop-up box. Patients could simply change their answer with no evidence that the prescriber (or Registrants) would know that this had been done.
56. Patients were asked for consent to contact their GP. By October 2019, prominent text would alert patients that consent would result in "significant delay" in processing orders. If consent was not given, then patients were informed that orders would normally be processed on the same day.

57. The website had a lock-out system to prevent patients from ordering more medication prior to a previous order's expiry. There was no clear cap of total orders. Contact with the patient appears to have been done by customer service teams of either Kalexiko or IMSL, as opposed to the prescriber or pharmacists at Homecare. Prescriptions were sent through electronically, printed and signed by DocuSign.
58. The website was reported as no longer taking orders on or around 17 October 2019. However, the website remained live until 16 June 2020 when Mr Aggarwal was asked to ensure changes were made to make it compliant with relevant guidance. At this point, Mr Aggarwal had the website taken down.
59. Homecare was the trading name of JIT and owned by JIT and/or 8PM Chemists. Mr Aggarwal and his brother, Vinesh Aggarwal ('VA') were directors within this group of companies. VA was the accountant of Homecare. Homecare had been operating since 1 April 2009 and acted as an internet/distance selling pharmacy. The physical premises were closed to the public and located on an industrial estate on the outskirts of Willenhall in the West Midlands.
60. Homecare's main activity during the relevant period was the dispensing of private prescriptions. Those prescriptions were predominantly received from UK Meds, and secondly from MyUKDoctor.
61. UK Meds sent electronic prescriptions to Homecare. Mr Aggarwal was the RP who dealt with dispensing the prescriptions, and Mr Bassi would occasionally cover. The payment structure was such that Homecare (or JIT) would be paid the cost of the product plus a dispensing fee only if the medicines prescribed were supplied.
62. Regarding MyUKDoctor, Homecare dispensed prescriptions which were almost entirely opiates and z-drugs. By October 2019, Homecare was dispensing approximately 200 prescriptions observed over a two day snapshot. Homecare received payments for each item supplied and were not paid if an order was declined.
63. Homecare was subject to two Council inspections in February 2019 and October 2019 respectively. Homecare was deemed to be performing satisfactorily in February 2019. In April 2019, further guidance was issued by the Council for pharmacies providing services from a distance, including on the internet.

64. On 16 October 2019, an unannounced and intelligence-led inspection was undertaken of Homecare. Deficiencies in the systems and processes were identified. On 18 October 2019, Homecare was subjected to Conditions not to supply controlled drugs of schedule 1-5 alongside amitriptyline and modafinil. The reasoning behind this was that there was:
- a. insufficient evidence of prescribers acting and prescriptions being issued in line with guidance (including GMC guidance),
 - b. insufficient assurance that risks associated with high-risk medications were managed adequately,
 - c. concern as to the quality of ID checks,
 - d. insufficient information obtained from patients to determine whether or not to supply,
 - e. concern as to the lack of information sharing with GPs; and
 - f. concern as to record keeping of decisions where no GP was identified.
65. Homecare was voluntarily removed from the Council's register on or around September 2022.
66. In short, it was the Council's case that the Registrants serious failures of due diligence, record keeping and risk management were all demonstrated with regard to the dispensing of high-risk medication, much of which carried serious risks of abuse and/or misuse.

Decision on Facts

67. 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.

68. The Committee noted that Mr Aggarwal had admitted allegations 1-10, 11.2-11.9, 13-13 and 16-19. Mrs Aggarwal had admitted all allegations 1-9. Therefore, pursuant to Rule 31(6), the facts of these allegations were found proved.
69. The Committee went on to consider the disputed allegations.
70. The Committee reminded itself that, when considering the allegations, it was important to confine itself to the particulars of allegation that each Registrant actually faced. The Committee reminded itself that memories are fallible and fade over time. To that end, the Committee bore in mind the importance of contemporaneous documentary evidence in comparison to the oral testimony received. The Committee took into account the good character of all the Registrants, which spoke to credibility and propensity.

Mr Mukesh Aggarwal

Allegation 11.1

71. The Committee considered this allegation to be **not proved**. The Committee considered that there was no requirement for MyUKDoctor to be regulated by a UK regulator at the relevant time. Dr Gupta was registered and regulated in Romania and therefore was permitted to prescribe for patients in the UK. In such circumstances, requiring Mr Aggarwal to carry out adequate due diligence that MyUKDoctor was regulated by a UK regulator would be an impossible burden for Mr Aggarwal to discharge.

Allegation 14

72. The Committee accepted the evidence of Mr Aggarwal that he was in India at the relevant time. This corresponded with the RP log reflecting that Mr Bassi was the RP at the time of the relevant check. The Committee did feel, on the evidence available before it, that it was more likely than not that Vinesh Aggarwal did conduct the checks as described as he was logged on to the system at the relevant time. As a result, his name was attributed to the relevant check. The Committee was not assisted by any evidence from Mr Bassi specifically speaking to this allegation. Nevertheless, on the balance of probabilities, it is accepted that Mr Aggarwal did not “allow” Vinesh Aggarwal to carry out checks. The Committee accepted the submissions of Mr Haycroft that “allowing” this situation would require some intent

and/or action on the part of Mr Aggarwal to facilitate this. Therefore, the Committee found this allegation **not proved**.

Allegation 15

73. The Committee noted that the evidence suggested that Mr Aggarwal recognised that there was an element of incentivisation to supply medications. Homecare was alive to the flaws in the payment scheme under which they operated. The Committee recognised that Mr Aggarwal made multiple failures to manage risks inherent to his business model. The Committee did not find that this linked to the payment scheme.
74. The Committee noted that there was nothing inherently unusual in how Mr Aggarwal received payments for dispensing medications. This was a normal payment scheme within the industry, and the Committee did not consider that Mr Aggarwal was abnormally managing this payment scheme. The Committee found that the evidence suggesting that there were a low number of refusals was inherently weak and did not support this particular.
75. Accordingly, the Committee found this allegation **not proved**.

Mr Amarjit Singh Bassi

Allegation 1

76. The Committee found that Mr Bassi had accepted, in his witness statement, that he was acting as an SI at the relevant time. The allegation reflects the duties of an SI. Accordingly, this allegation is found **proved**.

Allegation 2

77. The Committee noted that Mr Bassi had admitted acting as the SI during this specified period in his witness statement. Therefore this allegation was found **proved**.

Allegation 3

78. The Committee accepted the evidence of the quantity and category of prescription medications dispensed, provided by AM and NH. The Committee found this allegation **proved**.

Allegation 4

79. The Committee noted the report provided by Dr C. In particular, the Committee considered that Dr C's evidence and report was uncontested with regard to the elements of this allegation. It was evident that there were multiple failings with regards to the prescribing process used by UK Meds. These included:
- a. failing to obtain adequate patient information,
 - b. relying primarily on information in online questionnaires,
 - c. failing to access, or attempting to access, patients' GP records or specialist clinical records,
 - d. failing to request face-to-face consultations with patients to adequately determine clinical needs for medication,
 - e. failing to adequately consider the possibility of dependence and/or misuse; and
 - f. failing to refer patients back to their GP for appropriate assessments.
80. It was noted that Mr Bassi was the SI during this period, whilst Homecare was dispensing against this model. Thus, allegation 4 is found **proved in its entirety**.

Allegation 5

81. The Committee reminded itself of Dr C's evidence. During this period, Mr Bassi was the SI of Homecare. It is accepted that the medications had been prescribed repeatedly and that there was a failure to mitigate the risk of misuse on the part of patients. Thus, the allegation is found **proved**.

Allegation 6

82. The Committee again reminded itself of Dr C's evidence. It was clear that the medicines prescribed in Schedule B were not suitable for prescription solely on the basis of an online questionnaire. Mr Bassi was the SI at the relevant time and thus the Committee finds this allegation **proved**.

Allegation 7

83. This allegation is found **proved**. The Committee accepted that Mr Bassi was acting as the SI and that MyUKDoctor was providing pharmacy services at a distance.

Allegation 8

8.1

84. The Committee noted that allegation 8.1 for Mr Bassi reflected Mr Aggarwal's allegation 11.1. The Committee considered that there was no requirement for MyUKDoctor to be regulated by a UK regulator at the relevant time. Dr Gupta was registered and regulated in Romania and permitted to prescribe to patients in the UK by EU law. In such circumstances, requiring Mr Bassi to carry out adequate due diligence that MyUKDoctor was regulated by a UK regulator would be an impossible burden for Mr Bassi to discharge. Therefore, the Committee found allegation 8.1 **not proved**.

8.2

85. The Committee noted that Mr Bassi accepted in his witness statement that he simply relied upon Mr Aggarwal's knowledge of online pharmacies. Mr Bassi also accepted that he did not have sufficient knowledge of online pharmacies at the time. Therefore, the Committee found allegation 8.2 **proved**.

8.3

86. The Committee noted that Mr Bassi's witness statement laid out a position where, in effect, he abrogated his responsibilities as SI and relied upon Mr Aggarwal. The evidence therefore suggests that Mr Bassi did not properly assess the risks

associated with the model. This included the prescribers being based overseas and that a large number of medicines prescribed were liable to misuse and/or abuse. The Committee thus found allegation 8.3 **proved in its entirety**.

8.4

87. The Committee has seen the level of indemnity insurance held in place by the prescribers, amounting to €62,000 and accepted that this was nowhere near an adequate level of cover. Thus, the Committee found this allegation **proved**.

8.5 – 8.9

88. The Committee noted that Mr Bassi's evidence was that he relied entirely upon Mr Aggarwal and did not, in reality, exercise or discharge any of his responsibilities as SI. Therefore, it was evident that Mr Bassi was not ensuring that the prescribing model adequately safeguarded patients. Mr Bassi was also not ensuring that there were appropriate audits in place. The Committee reminded itself of SJ's unchallenged evidence that privacy policies were inadequate. The Committee reminded itself of the unchallenged evidence before it of the prescribing service not having a robust identity checks and that Mr Bassi had failed to ensure that prescribers had the relevant training and/or competence to prescribe. The Committee accordingly finds allegations 8.5-8.9 **proved**.

Allegation 9

89. The Committee again noted that Mr Bassi had, in effect, placed reliance upon Mr Aggarwal and did not seek to discharge his own responsibilities as SI. The Committee accepted that Mr Aggarwal had not adequately discharged the relevant duties himself. Therefore, the Committee found allegation 9 **proved in entirety**.

Allegation 10

90. The Committee has accepted that patients were not adequately safeguarded (see paragraph 89, above). The Committee also accepted the evidence of SJ that there

was no safeguarding policy in place. As a result, it was unclear if any of the staff were appropriately trained in safeguarding. Therefore, this allegation was found **proved**.

Allegation 11

91. The Committee noted that this allegation mirrored Mr Aggarwal's allegation 15. The Committee adopted its reasoning as outlined above for this allegation faced by Mr Bassi. Accordingly, the Committee found this allegation **not proved**.

Allegation 12

92. The Committee has seen the screenshots of the warnings provided to patients that giving consent to contact their GP would result in delays in fulfilling their orders. It was evident to the Committee that the effect of this warning would self-evidently dissuade patients from providing such consent. The Committee finds this allegation **proved**.

Allegation 13

93. The Committee reminded itself of Mr Bassi's evidence that he accepted that the risk assessment did not cover all the risks associated with the pharmacy service. The Committee noted that Mr Bassi's witness statement further noted that he regretted signing the document. The Committee has seen multiple examples of risk assessments exhibited within the evidence. The Committee noted that Mr Bassi did not identify which risk assessment he had signed. The Committee noted that this approach was demonstrative of the risk assessment process being treated akin to a checklist exercise rather than an ongoing process as it should have been. The Committee also found that this was indicative of Mr Bassi's approach towards risk assessment overall. Accordingly, the Committee found this allegation **proved in its entirety**.

Allegation 14

94. The Committee noted that Mr Bassi would have been responsible for ensuring that adequate Standard Operating Procedures were in place to mitigate the risks associated with supplying high-risk medicines at a distance as the SI. The Committee has also noted that Mr Bassi's position is that, in effect, he did not properly discharge his functions and responsibilities as an SI. The Committee examined the Standard Operating Procedures that had been in effect at the relevant time and accepted the evidence of SJ that they did not appropriately mitigate the specific risks associated with the supply of high-risk medications at a distance. Therefore, the Committee found this allegation **proved**.
95. The Committee also noted that Mrs Aggarwal had accepted that the Standard Operating Procedures, seen by the Committee, were inadequate at the time that she was acting as SI. It is evident that Mr Bassi did not improve upon this position.

Misconduct and Impairment

96. Having found some of the allegations proved, the Committee went on to consider whether the allegations found proved amounted to misconduct and, if so, whether the Registrants' fitness to practise is currently impaired.
97. The Committee took account of the guidance given as to the meaning of 'fitness to practise' in the Council's publication "*Good decision-making: Fitness to practise hearings and outcomes guidance*" (Revised March 2024) ('the Guidance'). 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.

Mrs Aggarwal

98. Mrs Aggarwal gave evidence at this stage. She stated that between August 2018 and October 2022 she had worked in two GP surgeries and had undertaken a PIP course. Subsequent to October 2022, she had been working as an RP and SI within one of the pharmacies. This included running the pharmacy, managing the staff and liaising with the GPs as appropriate. She has updated the logging of events within the pharmacy. This included a 'near miss' log, which would trigger team meetings. Laser stickers were used to trigger any concerns triggered by repeated requests, and this too would give rise to team meetings. She no longer works in remote dispensing services.
99. Mrs Aggarwal stated that her work within a GP setting has given her insight into the importance of consultations. She stated that she recognises the importance of face-to-face consultations, even by video link. Mrs Aggarwal stated that she had read the latest 2025 guidance. She stated that she believed that there remained an inherent risk in online questionnaire models and would not wish to ever return to an online model.
100. Mrs Aggarwal went on to express remorse and regret for her involvement with the failures recorded at Homecare.
101. During cross-examination, Mrs Aggarwal accepted that she had focused on the dispensing aspect of the model rather than the prescribing element at the relevant time. She further accepted that there was not a recognition of the risks and flaws inherent to the model and this was, therefore, not incorporated in the Standard Operating Procedures ('SOPs'). She accepted that the SOPs reflected the dispensing SOPs of UKMeds.
102. Mrs Aggarwal accepted that she should have been more proactive with regard to her duties as an SI. Rather, she simply took assurance from the lack of concerns raised. She accepted that she simply looked at the February 2019 inspection and accepted the outcome of satisfactory. She did not delve deeper into the document. She accepted that she did not undertake any audits during her stint as SI of Homecare. She did not accept that she was 'less concerned' about patient welfare whilst at Homecare, especially during her notice period. She stated that she would have carried out audits had she been there longer. She did accept that, with reflection, she should have been more proactive and that she should have been aware of the volume of high-risk prescriptions being dispensed.
103. Through her current practice, Mrs Aggarwal identified training shortcomings regarding the prescription of e.g. Folic acid. She became aware of these

shortcomings when patients were identified having been prescribed long-term indefinite prescriptions. Mrs Aggarwal identified that there appeared to be inconsistency in the knowledge of prescribers regarding relevant guidance for certain medications.

104. Mrs Aggarwal stated that her current role sees her dealing with very few private prescriptions and overwhelmingly dealing with NHS prescriptions. She does not exercise her abilities as a PIP. Mrs Aggarwal stated that during her time in Donnington, there were severe staff shortages within the GP practice and thus did not want to act as a PIP for fears of compromising patient safety. She returned to community pharmacy because she enjoyed the work and found community pharmacy to be rewarding.
105. Whilst being questioned by Mr Hoskins, Mrs Aggarwal was unclear as to whether or not she has the SI responsibilities in her current position. She stated that she was the pharmacy manager but was not sure if was still the SI.
106. Currently, Mr Aggarwal will cover for Mrs Aggarwal when she is unavailable as a locum. She stated that she finds him very experienced and very good as a locum.
107. In response to questions from the Committee, Mrs Aggarwal stated that with hindsight she felt that Mr Aggarwal should have had concerns and should have passed these concerns on to her. Mrs Aggarwal stated that Mr Aggarwal covers her as a locum RP when she is not available. There have been times when she has been the SI when Mr Aggarwal has been acting as a locum RP. In light of her experiences at Homecare, she stated that she had not changed her approach towards Mr Aggarwal when supervising him in her capacity as SI.
108. It was Mrs Aggarwal's understanding that her parents-in-law owned the Homecare business. She was not aware that Mr Aggarwal was the legal owner and that his parents were beneficial owners. She stated that she did not see any conflicts of interest in Mr Aggarwal acting as her boss whilst she had the role of SI. She clarified that she was sure that she was no longer the SI of the Medical Centre Pharmacy and had not been for approximately 12 months. She stated that her husband, Sukesh Aggarwal, was the SI. She stated that she was unsure earlier when being questioned by Mr Hoskins due to nerves and the emotions of being cross-examined at the time. Mr Aggarwal does not have any role beyond locum RP at Medical Centre Pharmacy. Mrs Aggarwal confirmed that Vinesh Aggarwal does the paperwork and accounts at Medical Centre Pharmacy. She stated that she thought that Vinesh Aggarwal might

be the owner of Medical Centre Pharmacy; he acts as her boss. She did not consider this arrangement to carry any potential conflicts of interest.

109. During re-examination, Mrs Aggarwal was unable to confirm why she stopped being the SI. She stated that this was a decision that was taken by management and not by herself. She did not know the rationale behind this. She confirmed that as SI she would be responsible for supervision. She considered Mr Aggarwal to be “management.” She did not report to him as such. When he was acting as an RP, she would provide advice as required. During her time working with Mr Aggarwal she had not had any concerns around Mr Aggarwal’s dispensing abilities. She confirmed that although her husband was now acting as the SI, if she had concerns, she would feel comfortable raising them.

Mr Aggarwal

110. Mr Aggarwal gave evidence at this stage. He stated that he has done a PIP course, which he completed in 2019. He did this course in order to be able to work in a GP surgery. He now works in a position whereby most of the prescriptions he dispenses come from the NHS and not privately. He explained that when presented with high-risk medications, such as opioids, when a patient presents a third or fourth prescription, he will speak to the patient and the GP.
111. Mr Aggarwal explained that his understanding of high-risk drugs had evolved. He believed that the only safe way to prescribe such drugs was via face-to-face appointments. He explained that he had undertaken CPD, particularly with regard to remote prescriptions. He highlighted that he had learned significantly from the previous reliance by Homecare on online questionnaires. He explained that face-to-face consultations were necessary because patients can forget key details and also to ensure that patients are giving truly informed consent.
112. He reiterated that he would not work in an online pharmacy again. He explained that the risks of not being able to assess, e.g. patients’ capacity and gaining proper informed consent were too great.
113. Mr Aggarwal was cross-examined. He stated that he was still shocked at the collective errors in judgement that underpinned the system at Homecare. He focused on individual areas of compliance rather than looking at the whole picture. He explained that he now wished to remain in community pharmacy because this was

an area that he knew well. He acknowledged that the risk for systemic failures always existed, however, he maintained that they were reduced by his experience in community pharmacy.

114. Mr Aggarwal explained that with the passage of time and having concluded his CPD, he felt more confident to use and step into a prescribing role. Mr Aggarwal explained that Croft Pharmacy and Medical Centre Pharmacy were one and the same entity. Therefore, Mr Aggarwal was working as a locum RP at Medical Centre. He explained that 8PM chemists had 3 branches, therefore, in total he was working at four pharmacies.
115. Mr Aggarwal explained that he understood the necessity of prioritising patient safety over and above any innovation in the sector. He now kept a log of his learnings. He explained that they were not a 'diary' as such.
116. Mr Aggarwal explained during re-examination that he was more aware of flaws within individual models. He explained that unless failures were systemic and missed by the majority of those working within systems, he would pick these up. He further explained that the NHS' linkage and oversight with the Care Quality Commission ('CQC') also allowed him greater comfort due to the increased level of oversight. Mr Hoskins explored the possible similarities between dispensing in an online setting and dispensing at a distance for care homes. Mr Aggarwal explained that distance prescribing in care home settings was very different. Such prescriptions were issued by GPs familiar with the patients and the medications were only prescribed after face-to-face assessments and proper monitoring from the GP. Mr Aggarwal explained that this was remarkably different to an online questionnaire model.
117. In response to a question from the Committee, Mr Aggarwal confirmed that he did not see any potential conflicts of interest in him being legal owner and RP at Homecare whilst Mrs Aggarwal was acting as SI and, effectively, reporting to him or seeing him as her boss.

Decision on misconduct

118. When considering whether the particulars found proved amounted to misconduct the Committee took into account the Guidance.

119. The Committee heard submissions from Mr Hoskins for the Council and from Mr Haycroft for Mr and Mrs Aggarwal.
120. Mr Hoskins submitted that each Registrant must be assessed separately. He submitted that the following standards had been breached:
- a. Standard 1 – providing person centred care,
 - b. Standard 2 – working in partnership with others,
 - c. Standard 3 – pharmacy professionals must communicate effectively,
 - d. Standard 4 – pharmacy professionals must maintain, develop and use their professional knowledge and skills,
 - e. Standard 5 – use professional judgment,
 - f. Standard 8 – speak up when they have concerns or when things go wrong, specifically telling relevant authorities about concerns; and
 - g. Standard 9 – pharmacy professional must demonstrate leadership.
121. Mr Hoskins submitted that the misconduct fell at the higher end of the spectrum as it was fundamental, systemic and wide-ranging. Mr Hoskins submitted that it was not simply the professional standards that had been breached. Specific guidance (as listed in the allegations) had been breached. Mr Hoskins referred to the guidance for PIP qualifications which the Aggarwals would have had knowledge of. Mr Hoskins submitted that the Aggarwals were not naïve, they were experienced pharmacists. Mr Hoskins accepted that the Council's guidance changed over time, however, he submitted that these were changes of degree and not kind. Mr Hoskins submitted that the guidance was always effective at flagging risks. Consequently, Mr Hoskins submitted that the Registrants had not fallen foul of a gradually tightening regulatory net.
122. Mr Hoskins submitted that the Registrants fell at the upper end of the scale of misconduct. He submitted that all Registrants were very experienced. Mr Hoskins accepted that it was possible Mr Bassi and Mrs Aggarwal had come quite newly to the SI role. However, their years of experience would have given them plenty of insight into what was expected of them as SIs. Mr Hoskins also highlighted that there were at least two Registrants who had undertaken the first part of the PIP course and thus did not come to prescribing with no knowledge.

123. Mr Hoskins submitted that there was a course of conduct covering significant failures. Mr Aggarwal's conduct spanned an approximately 1.75 years'. Mr Hoskins submitted that there remained a paucity of risk assessments. He went to submit that Mr Bassi's conduct spanned a little over a year. Mrs Aggarwal acted as SI for approximately seven months. This was not, in Mr Hoskin's submission, a negligible period of time.
124. Mr Hoskins submitted that comparison between Homecare's numbers and large-scale pharmacies would not be helpful. Rather, it was important to look at the numbers for what they were. Mr Hoskins went on to submit that if Mr Bassi's statement was correct about the sharing of the questionnaires, then Homecare was "flying blind" when dispensing prescriptions. This amounted to a wholesale failure in a wide-ranging set of standards.
125. Mr Hoskins submitted that the model in which Mrs Aggarwal and Mr Bassi were working allowed them to wholly abrogate their duties and responsibilities of an SI.
126. Mr Haycroft accepted that there was misconduct on the part of the Aggarwals. However, he submitted the following with regard to the standards highlighted by Mr Hoskins:
- a. Standard 1:
 - i. Mr Haycroft submitted that the Aggarwals were inherently person centred in their approach. He submitted that CPD had been undertaken.
 - b. Standard 2:
 - i. It was submitted that the Aggarwals did in fact work in partnership with each other and carried out due diligence when setting up the business working with UK Meds. It was submitted that they did contact GPs on occasion.
 - c. Standard 3:
 - i. It was submitted that GPs were communicated with, albeit the flaws in the model prevented his from being as effective as it should have been.
 - d. Standard 4:
 - i. It was submitted that the Aggarwals did maintain, develop and use their professional knowledge and skills, save as to persisting working within the flawed model.

e. Standard 5:

- i. It was submitted that the Aggarwals did use their professional judgment and attempted to act in patients' interests albeit within the constraints of a model that would not allow this to be as effective as it should have been.

f. Standard 8:

- i. It was submitted that Registrants should be on notice and realise that something is required of them. In short, it was Mr Haycroft's submission that this should be seen as an intentional breach and had not been alleged as a specific allegation by the Council.

g. Standard 9:

- i. Mr Haycroft made the same submissions as to Standard 8 with regard to this Standard.

127. Ultimately, Mr Haycroft submitted that there were failures in the model that led to the failures. The failures of the Registrants were therefore to be seen within the context of their levels of awareness of the failures and deficiencies inherent to the model.

128. Mr Haycroft submitted that this was not a case where no due diligence had been undertaken, rather there had been, but in a flawed manner. There were refusals of prescriptions for example. Mr Aggarwal left UK Meds as he became aware of the flaws in the model. Therefore, Mr Haycroft submitted that the Registrants' efforts were not adequate, but not non-existent in terms of mitigating risks.

129. Mr Haycroft submitted that the Registrants were experienced pharmacists. They were, however, new to online pharmacies. He accepted that the Aggarwals should have done more. However, they also explained where they lacked confidence and where they did not practise skills as a result. Mr Haycroft submitted that nothing that the Aggarwals did could have overcome the inherent failings in the model.

130. Mr Haycroft submitted that the guidance had changed 6 times over the course of 10 years and twice since these events. This was an unprecedented state of affairs. Mr Haycroft submitted that Council guidance made reference to (undefined) "pharmacy owners" and had since been updated to include SIs. Mr Haycroft submitted that SJ had missed this change herself, despite her job. Mr Haycroft submitted that there had been a regulatory tightening.

131. Mr Haycroft submitted that Mr Aggarwal's conduct spanned less than two years. In this time, Mr Aggarwal developed concerns with UK Meds. As a result of these concerns, Mr Aggarwal set about bringing nine improvements to the service. However, none of these improvements could have overcome the main failings of the model. Mr Haycroft submitted that previous inspections had led to satisfactory findings. Mr Haycroft highlighted that there was a change in guidance in April 2019. This change led to the inspection outcome of October 2019. He further submitted that Mr Aggarwal was not provided with any training or assistance by the Council after these inspections and changes. In his submission, the Council chose to send the new guidance to select pharmacies and inviting them to send SOPs. It was, therefore, unfair to target pharmacies signed up to a scheme, rather than all pharmacies.
132. Mr Haycroft submitted that the Council should be committed to helping pharmacies improve and meet the standards. Mr Haycroft submitted that a level playing field had not been maintained. He submitted that the Council had not shown a commitment to light touch regulation in this matter. Some pharmacies were helped, others, such as this one, were not.
133. Mr Haycroft further submitted that Mrs Aggarwal's attention was brought to this matter some six years after her having left Homecare.
134. Mr Haycroft submitted that this misconduct did not fall near the top of the spectrum. In his submission, if it did fall at the top, then cases featuring e.g. dishonesty, a lack of integrity, deliberate circumvention of rules etc would be diminished. He accepted that the conduct was a pattern and did not fall at the bottom of the spectrum but was not at the top end.
135. The Committee was given legal advice reminding it that the word misconduct was one of "general effect" and must be sufficiently serious. The Committee was directed to the following case law:
- a. Roylance v General Medical Council (No2) [2000] 1 AC,
 - b. Nandi v General Medical Council [2004] EWHC 2317 (Admin),
 - c. Remedy UK Ltd v General Medical Council [2010] EWHC 1245 (Admin); and
 - d. Khan v Bar Standards Board [2018] EWHC 2184 (Admin).

136. The Committee considered whether the Registrants had breached any of the Council's Standards for Pharmacy Professionals (May 2017). The Committee determined that there had been a breach of the Standards:
- a. Standard 1 – providing person centred care,
 - b. Standard 2 – working in partnership with others,
 - c. Standard 3 – pharmacy professionals must communicate effectively (only for Mr Aggarwal),
 - d. Standard 4 – pharmacy professionals must maintain, develop and use their professional knowledge and skills,
 - e. Standard 5 – use professional judgment,
 - f. Standard 8 – speak up when they have concerns or when things go wrong, specifically telling relevant authorities about concerns (only for Mr Bassi); and
 - g. Standard 9 – pharmacy professional must demonstrate leadership.
137. 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).

Mr Aggarwal

138. The Committee determined that Mr Aggarwal had the most involvement in how Homecare was operating at the material times. Mr Aggarwal accepted that the model under which he operated failed to capture core elements of informed consent. The lack of consultation with patients, coupled with placing reliance upon UK Meds demonstrated a prescription centred service rather than a patient centred service. The Committee therefore determined Mr Aggarwal had breached Standard 1.
139. The Committee reminded itself that Mr Aggarwal had admitted e.g. in allegations 4 and 12 that the flaws in the system allowed Mr Aggarwal to dispense prescriptions without adequately obtaining patients' health records. The failing to take proper steps to obtain the full picture of patients' healthcare needs, concerns and/or vulnerability show a breach of Standard 2.

140. The Committee reminded itself of the conduct admitted by Mr Aggarwal in e.g. allegations 13-17. It was clear that patients were e.g. dissuaded from allowing contact with their GPs. Alongside this, there was a lack of safeguarding and a failure to communicate any safeguarding information to patients. Accordingly there was a failure to adapt communication to patients, to check that patients understood information/risks associated with medicines dispensed and failures to communicate effectively with others involved in the care of the person. Accordingly the Committee determined Mr Aggarwal had breached Standard 3.
141. The Committee noted Mr Aggarwal's case was that he was an experienced pharmacist but was new to online pharmacy. It was therefore self-evident to the Committee that Mr Aggarwal failed to recognise and work within the limits of his knowledge and skills. Mr Aggarwal also conceded that that he was left to his own devices to build upon his knowledge and skills, it is unclear to whom he referred at the relevant time to remedy this. Accordingly, the Committee found that Mr Aggarwal had breach Standard 4.
142. The Committee reminded itself of the conduct admitted by Mr Aggarwal in e.g. allegations 5-7 that Mr Aggarwal was dispensing without the information required to provide appropriate care. In turn, it was evident that the care of the person was not the first concern and nor was Homecare acting in patients' best interests. There was further a failure to consider and manage the service such that it properly reflected the needs of the patients. Accordingly, the Committee found Mr Aggarwal had breached Standard 5.
143. The Committee noted that Mr Aggarwal effectively accepted a series of personal failings in risk management. Therefore, it is obvious to the Committee that Mr Aggarwal did not assess the risks in the care he provided and he did not do everything that he could to keep the risks as low as possible. The Committee therefore finds that Mr Aggarwal breached Standard 9.

Mrs Aggarwal

144. The Committee noted Mrs Aggarwal's admission in e.g. allegations 4-8. The lack of consultation with patients, coupled with placing reliance upon UK Meds demonstrated a prescription centred service rather than a patient centred service. The Committee therefore determined Mrs Aggarwal had breached Standard 1.

145. The Committee noted Mrs Aggarwal's admission in e.g. allegation 4. It was evident that as SI, she oversaw the running of a model that allowed prescriptions to be dispensed without adequately obtaining patients' health records. The failing to take proper steps to obtain the full picture of patients' healthcare needs, concerns and/or vulnerability show a breach of Standard 2.
146. The Committee noted that Mrs Aggarwal was the SI at Homecare. Therefore, unlike Mr Aggarwal's role. In those circumstances, it was not for Mrs Aggarwal to engage in patient communication in the same manner that it would have been incumbent upon Mr Aggarwal. Therefore, the Committee did not find a breach of Standard 3 with regard to Mrs Aggarwal.
147. The Committee noted that Mrs Aggarwal was an experienced pharmacist. She left Homecare to begin her PIP course. However, it is obvious that Mrs Aggarwal did not recognise and work within the limits of her knowledge and skills in the context of online pharmacy work. Accordingly, the Committee found a breach Standard 4 with regard to Mrs Aggarwal.
148. The Committee noted that Mrs Aggarwal admitted that she ought to have understood the risks in the model and done more to protect patient safety. As a result it was evident that Mrs Aggarwal failed to make patient safety her primary concern. Therefore, a breach of Standard 5 was found in regard to Mrs Aggarwal.
149. The Committee noted that unlike Mr Aggarwal, Mrs Aggarwal was acting as an SI at Homecare. She was therefore in a position of leadership. Mrs Aggarwal accepted that she should have read the 15 February 2018 inspection report of UK Meds. However, Mrs Aggarwal admitted that she confined herself to reading the determination of 'satisfactory' and decided to not read any further than this. The Committee noted that the document was not particularly long. It was therefore evident that Mrs Aggarwal failed to properly discharge her duty as SI and failed to demonstrate leadership in this context. By failing to address the detail of the report, she deprived herself of the opportunity to take any remedial actions. It is also evident that Mrs Aggarwal did not assess the risks in the care being provided by Homecare and certainly did not do everything she could to keep the risks as low as possible. Accordingly, the Committee found a breach of Standard 9 in relation to Mrs Aggarwal.

Mr Bassi

150. The Committee noted its findings relating to Mr Bassi's conduct in e.g. allegations 4-9. The lack of consultation with patients, coupled with placing reliance upon UK Meds demonstrated a prescription centred service rather than a patient centred service. The Committee therefore determined Mr Bassi had breached Standard 1.
151. The Committee noted its findings relating to Mr Bassi's conduct in e.g. allegations 4 and 9. It was evident that as SI, he oversaw the running of a model that allowed prescriptions to be dispensed without adequately obtaining patients' health records. The failing to take proper steps to obtain the full picture of patients' healthcare needs, concerns and/or vulnerability show a breach of Standard 2.
152. The Committee noted that the allegations faced by Mr Bassi pertained to his role as SI. There was evidence before the Committee that Mr Bassi had acted as an RP on some few occasions. However, the Committee noted that none of the alleged conduct pertained to Mr Bassi as an RP. Therefore the Committee found Mr Bassi to be in a similar position to Mrs Aggarwal and accordingly did not find a breach of Standard 3.
153. The Committee noted that Mr Bassi stated that he had no knowledge or prior experience of online pharmacy in his witness statement. It is therefore self-evident that Mr Bassi was working well outside the scope of his knowledge and skills. Therefore the Committee found a breach of Standard 4.
154. The Committee noted that Mr Bassi's position was similar to Mrs Aggarwal's in many respects. However, in addition to this, Mr Bassi admits to working outside the scope of his knowledge and skills. He stated that he was, in effect, acting as SI in name only, failing to discharge any of his statutory duties. It is therefore obvious that he failed to recognise the limits of his competence and was the SI of a service that failed to make patient care its primary concern. Therefore the Committee found a breach of Standard 5 in regard to Mr Bassi.
155. The Committee noted that Mr Bassi was a highly experienced pharmacist. His witness statement suggested that he came to Homecare to function as an SI in name only. He accepted that he joined Homecare outside the scope of his knowledge and

experience. These were all concerns that Mr Bassi had a duty to promptly and candidly report to all relevant authorities, including the Council. Therefore, the Committee finds a breach of Standard 8 in regard to Mr Bassi.

156. The Committee noted that Mr Bassi's position was, that despite taking on the role of SI, he did not discharge any of the duties associated with the office. As an SI in name only, he was self-evidently failing to demonstrate leadership. Given Mr Bassi's level of experience, this wholesale abrogation of responsibility demonstrates a stark breach of Standard 9.
157. The Committee therefore found that the conduct of the Registrants were serious failings that did amount to misconduct.
158. The Committee therefore did go on to consider whether the Registrants' fitness to practise is impaired.

Decision on Impairment

159. Having found that the particulars of allegation amounted to misconduct, the Committee went on to consider whether the Registrants' fitness to practise is currently impaired. In doing so the Committee considered whether the particulars found proved show that actions / omissions of the Registrants:
 - *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.*
160. Mr Hoskins submitted that the Registrants were all currently impaired. Mr Hoskins submitted that there were two-routes to calculate impairment. He submitted that members of the public would find it abhorrent to learn how many high-risk medications were dispensed by Homecare. He submitted that members of the public must place reliance upon the skills of pharmacists and place trust within them to exercise clinical skills and judgment.

161. Mr Hoskins submitted that this matter reflected fundamentals of prescribing and dispensing practice. His submission was that it could not be acceptable for any Registrant to simply suggest that they were unaware of their responsibilities as SI. Mr Hoskins submitted that the experience of the Registrants alone suggested that it would be harder to effectively remediate the misconduct.
162. Mr Hoskins submitted that insight was crucially important to demonstrate remediation. Mr Hoskins accepted that the Aggarwals had apologised unreservedly and had fully engaged with these proceedings. Mr Hoskins submitted that Mr Bassi had provided generic responses in his witness statement and had not attended these proceedings. Mr Hoskins submitted that Mr Bassi's statement was less apologetic. The issue for the Committee, *per* Mr Hoskins, was to assess if Mr Bassi was apologising for being involved with Homecare, or if he had assessed the risks he had inherently taken. Mr Hoskins further submitted that Mr Bassi had sought to push much blame on to others. Mr Hoskins reminded the Committee that retirement from the profession was no bar to the finding of impairment.
163. Mr Hoskins submitted that the Aggarwals demonstrated a degree of minimisation. Mr Hoskins submitted that there may be some degree of truth to a lack of knowledge of the true picture at UK Meds. However, Mr Hoskins submitted that Mrs Aggarwal had conceded that she should have been aware of these things. Mr Hoskins further submitted that Mr Aggarwal had not dealt with issues immediately even when made aware of them at UK Meds.
164. Mr Hoskins submitted that both Aggarwals had demonstrated some insight. However, he invited the Committee to consider the extent and depth of the insight shown. He asked if the Aggarwals had asked themselves what fundamentally needed to change about their practice.
165. Mr Hoskins submitted that there remained a residual risk of repetition on the part of the Registrants.
166. Mr Haycroft submitted that there was no current public protection issue. However, he conceded that there may be impairment on public interest grounds.
167. Mr Haycroft submitted that impairment could only be found in relation to the matters found proved (i.e., that which had been formally alleged). Therefore, all CPD was relevant and demonstrated a commitment to safe practice. Mr Haycroft further

submitted that the risk of repetition also pertained only to the matters set out. That is, the Committee was invited to ask if there was a risk of repetition of this conduct, not tangential and unalleged conduct.

168. Mr Haycroft submitted that it had been over six years for Mr Aggarwal and over seven for Mrs Aggarwal since the matters alleged had come to an end, not since they began. In that time, they had continued to practise safely.
169. Mr Haycroft submitted that there was a low risk of repetition. This was because of a greater appreciation of risk and a determined decision to steer clear of online pharmacies. Both Aggarwals had undertaken CPD and reached reasoned and sensible positions as to why they would not wish to work in such environments ever again.
170. The Committee received legal advice on impairment. The Committee was reminded that the purpose of regulatory proceeding was to protect the public and not to punish the Registrants. The Committee was also reminded that impairment was forward looking. Finally, the Committee was reminded that findings of impairment may be compelled in matters of sufficient seriousness. The Committee was directed to the following case law:
 - a. Cheatle v General Medical Council [2009] EWHC 645 (Admin),
 - b. Cohen v General Medical Council [2008] EWHC 581 (Admin),
 - c. CHRE v (1) Nursing and Midwifery Council and (2) Grant [2011] EWHC 927 (Admin),
 - d. Bijl v General Medical Council [2001] UKPC 41; and
 - e. Fopma v General Medical Council [2018] EWHC 714 (Admin).

Public Interest

171. The Committee was of the view that members of the public would be shocked by the manner in which Homecare was run and resultantly the reputation of the pharmacy profession would be diminished in the eyes of the public. The Committee accepted the submissions of Mr Hoskins that members of the public are entitled to have faith that pharmacists exercise proper judgment and skill when dispensing medication. The Committee found that this matter has the ability to erode faith in the pharmacy profession as a whole.

172. The Committee reminded itself of the scale of high-risk medications being dispensed by Homecare. This carried a risk of significant harm to a large number of people, including vulnerable patients. The Committee noted Mr Haycroft's submissions regarding the inherent reliability of the specific numbers of medications dispensed. However, the Committee noted that the overall scale was not disputed by Mr Haycroft.
173. The Committee found that all of the Registrants had acted in a manner that placed members of the public at risk, had breached the standards of the profession and brought the profession into disrepute.
174. The Committee therefore found that all the Registrants' fitness to practise was currently impaired on public interest grounds.

Public Protection

Mrs Aggarwal

175. The Committee had concerns around Mrs Aggarwal's seeming confusion about if she was still acting as an SI. The Committee recognised that Mrs Aggarwal's explanation was that of nerves at the hearing. The Committee accepted that Mrs Aggarwal may have been nervous, it was of the view that she ought to have known if she was, or was not, acting as the current SI. The Committee also noted that it was only around this question that she demonstrated such confusion.
176. The Committee also recognised that after her experience with online pharmacy work, Mrs Aggarwal has returned to working purely within the community. This is an area with which she is familiar. To this extent, the Committee recognised that Mrs Aggarwal was demonstrating a degree of remediation.
177. The Committee felt that there was some insight on the part of Mrs Aggarwal. However, the Committee felt that there remained a degree of risk of repetition. Mrs Aggarwal continues to work within a family structure. This structure blends issues of ownership, management and statutory roles. It is unclear how these duties are formally structured to manage risks appropriately. It remained unclear who reports

to whom in this structure. The Committee would have been greatly assisted by an understanding of how roles within the Aggarwals' family business were formalised and how responsibilities managed to ensure proper risk management. Mrs Aggarwal asserted that she saw no potential conflicts of interest that required her management when her statutory role as SI was potentially compromised by having to effectively report to Mr Aggarwal who she perceived as being her 'boss.'

178. The Committee retained concerns, in light of the above, that Mrs Aggarwal remained inherently unclear on who the current SI is within the Aggarwals' current business. The Committee also had some concerns that Mrs Aggarwal remained somewhat reactive as opposed to proactive in terms of risk management.
179. As a result, the Committee found that there remained some risk of repetition on the part of Mrs Aggarwal. The Committee found that some of the risk had diminished due to the passage of time and Mrs Aggarwal's CPD. However, the Committee felt, overall, that the risk of repetition, whilst diminished, remained unacceptably high. The Committee felt that the issues that arose in Homecare did so, in part, due to an absence of scrutiny that would have existed had the statutory role of the SI been properly discharged.
180. The Committee therefore found Mrs Aggarwal to be currently impaired on public protection grounds.

Mr Aggarwal

181. The Committee felt that there was some insight on the part of Mr Aggarwal. The Committee retained all the concerns around the structure of the Aggarwals' businesses as highlighted above.
182. The Committee noted that Mr Aggarwal's working context was different from Mrs Aggarwal's. The Committee did note that Mr Aggarwal's position currently was that true governance requires structure and willingness to challenge. However, it remained unclear how the Aggarwals' current business meets this standard. There remains a structure in which family members will blend the relationship of boss and employee, manager and managed, family and statutory roles. How these waters are navigated formally remained unclear. Mr Aggarwal, as with Mrs Aggarwal, did not

recognise the potential conflict of interest that arose from the blurring of roles. Therefore, he was unable to manage the risks associated with them.

183. The Committee recognised that some remediation has happened in light of CPD and the passage of time. However, the Committee found that there remained a risk of repetition insofar as the robustness of the governance structure within the Aggarwals' current business. The Committee found that the risk of repetition, whilst diminished, remained unacceptably high. The issues that arose in Homecare did so, in part, due to an absence of scrutiny that would have existed had the statutory roles of the RP and SI been properly discharged.
184. The Committee therefore found Mr Aggarwal to be currently impaired on public protection grounds.

Mr Bassi

185. The Committee only had Mr Bassi's witness statement in evidence before it. The Committee recognised that Mr Bassi expressed remorse. The Committee recognised that Mr Bassi's position was that he acted as an SI in name only. He exercised none of his statutory duties and had no knowledge of online pharmacy. The Committee has seen no evidence of remediation or insight from Mr Bassi. The Committee recognised that Mr Bassi had stated that he was retired now.
186. The Committee considered that Mr Bassi's explanation of his role in Homecare to be a reflection of attitudinal concerns regarding the discharge of his statutory duties. The Committee finds that the integrity of Mr Bassi can no longer be relied upon and that it would be very difficult to demonstrate remediation of a complete abrogation of responsibilities.
187. As a result, the Committee found that there remained a risk of repetition. The Committee therefore found Mr Bassi to be currently impaired on public protection grounds.
188. In respect of all of the Registrants, the Committee found that they had all engaged in conduct described at Rule 5(2) of the Rules, namely:

- a. Presenting an actual or potential risk to patients and/or the public,
 - b. Bringing the profession of pharmacy into disrepute,
 - c. Breaching one or more of the fundamental principles of the profession of pharmacy; and
 - d. In the case of Mr Bassi, demonstrating that his integrity can no longer be relied upon.
189. The Committee therefore finds all of the Registrant's current fitness to practise to be impaired on public protection and interest grounds and accordingly went on to consider the issue of outcome.

Decision on Outcome

190. Having found impairment, the Committee went 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 most appropriate and proportionate outcome that meets the circumstances of the case.
191. The purpose of the outcome is not to be punitive, though an outcome may 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.
192. 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.
193. The Committee took into account the submissions made by Mr Hoskins and Mr Haycroft. The Committee accepted the advice of the Legally Qualified Chair.
194. The Committee first considered what, if any, aggravating and mitigating factors there may be.
195. The Committee identified the following aggravating factors, including:
- a. The duration of the misconduct was significant for all of the Registrants. The Committee recognised that the relevant period for Mrs Aggarwal and Mr Bassi was shorter than that of Mukesh Aggarwal.
 - b. The level of harm and impact upon others was significant. The misconduct in relation to all three Registrants placed patients at an unacceptable level of risk and that risk was especially acute for vulnerable patients. Not only was

there evidence of significant risk of harm but also of actual harm occasioned to patients.

c. The misconduct involved controlled drugs and high-risk medications.

196. In relation to Mr Bassi, the Committee noted the specific submissions of Mr Hoskins that reinforced the long period over which the misconduct continued and the specific reference to patients that had been harmed, including Patient 10. The Committee noted its previous finding in relation to Mr Bassi in that his integrity had been called into question as a result of his misconduct and that he had failed to uphold the duties required in his statutory role as Superintendent Pharmacist.
197. The Committee further noted the representations made by Mr Hoskins in relation to Mrs Aggarwal. Mrs Aggarwal had also failed to uphold the requirements of her role as Superintendent Pharmacist at Homecare. The Committee concluded that a lack of proper scrutiny by Mrs Aggarwal was, in part, responsible for the inadequacy of the systems that should have prevented the unacceptable risk to patient safety. The Committee found that these failings arose not out of a casual disregard for patient safety but out of a failure to fully appreciate the role of Superintendent Pharmacist within a business structure where there was a blurring of lines between the roles of business owner and manager and the statutory roles of Superintendent Pharmacist and Responsible Pharmacist.
198. In relation to Mr Aggarwal, the Committee acknowledged that he had a different and lesser statutory role as Responsible Pharmacist within Homecare. However, Mr Aggarwal also demonstrated that he was a pivotal and driving force behind the business moving into online dispensing. The Committee also recognised that as a Responsible Pharmacist Mr Aggarwal would have had day to day awareness of the changes once online dispensing had commenced. This would have included observing high risk medication being dispensed in significant quantities within an unorthodox prescribing model with which he, and his colleagues, had little if any experience. The risks were significant and should have been obvious.
199. The Committee noted Mr Hoskins submissions that the conduct in respect of all three Registrants was so serious, and the ongoing risk to the public so grave, that the only appropriate outcome was removal from the register.
200. The Committee identified mitigating features including:
 - a. All of the Registrants were of good character and demonstrated long and unblemished careers.
 - b. Mr Aggarwal and Mrs Aggarwal had made full admissions. The Committee noted that Mr Bassi had made generic admissions, but he had not offered any formal admissions to the particulars of the charge.

- c. Genuine remorse and regret had been expressed by all Registrants including Mr Bassi within his written submissions.
- d. The periods that the Registrants engaged in the overall misconduct were different for each but the Committee found this affords limited mitigation for those who were involved for a shorter time than others. Each was involved for a significant period. Also, the Committee acknowledged the submissions that the relevant guidance for online dispensing and prescribing changed between 2018 and 2025 on a number of occasions. However, the changes in the guidance also affords limited mitigation. There was non-compliance throughout the period in question. The risks should have been obvious to a competent pharmacist.
- e. The Committee accepts that Mr Aggarwal and Mrs Aggarwal engaged positively with the investigative process throughout. Mr Bassi also engaged but chose not to attend the hearing. The Committee noted that there is an expectation of compliance with a regulator and so there is limited credit for this.
- f. The misconduct found proved was between 6 and 7 years ago and there has been no repetition or any other conduct issues of concern for any of the Registrants. The Committee acknowledges that these proceedings have been hanging over the Registrants for a considerable period of time and would have caused prolonged stress and anxiety. The Committee also recognised that significant steps towards remediation have begun and noted the good work prior to the hearing as demonstrated in the reflective evidence of Mr Aggarwal and Mrs Aggarwal.
- g. The Committee noted the submissions made by Mr Haycroft that some elements of due diligence had been undertaken before the Registrants embarked upon the flawed business model both in respect of UKMeds and MyUKDoctor. However, the Committee noted that it was the inadequacy of such checks that formed the basis of the majority of the particulars against the Registrants. That there were some, albeit insufficient, steps taken towards due diligence the Committee found to neither mitigate nor aggravate the findings in this case.
- h. Mr Haycroft submitted that Mr Aggarwal did raise concerns with the UKMeds SI and Clinical Lead and then chose to stop working with them. He also submitted that although the MyUKDoctor model was also flawed it was less so than UKMeds. Mr Haycroft also raised that Mr Aggarwal suspended the work with MyUKDoctor after the GPhC intervention in October 2019. The Committee did not see significant mitigation in this. The flaws in the UKMeds system were largely replicated at MyUKDoctor. Although the Committee notes that the systems improved, they remained a significant threat to patient safety.

- i. The Committee accepts the written submissions of Mr Haycroft that, in respect of Mr Aggarwal and Mrs Aggarwal, the misconduct did not involve deliberate or calculated breaches of the standards nor was there a lack of integrity and that the misconduct did not involve an abuse of position or an abuse of trust. However, the Committee considers that these represent an absence of what would otherwise be aggravating factors and cannot be accurately described as mitigating features. These findings have equal application to Mr Bassi.
- j. The Committee also accepted the written representations of Mr Haycroft that there was no financial motive for the misconduct for either Mr Aggarwal or Mrs Aggarwal. The Committee further concluded that this had equal application to Mr Bassi.
- k. The Committee noted the extensive testimonials provided to support Mr Aggarwal and Mrs Aggarwal. Mr Bassi had not produced any testimonials but the Committee makes clear that the absence of testimonials did not adversely affect the Committee's approach towards Mr Bassi.

Mr Aggarwal produced 26 testimonials from individuals that had known him for many years and, in some cases, decades. These included both personal and professional character references and each attested to their individual shock at hearing of the allegations. One testimonial referenced how their knowledge of the allegations "*sat uncomfortably*" with their knowledge of Mr Aggarwal. The testimonials talk of the chastening effect of these proceedings. A number of testimonials talk of the Registrant's close liaison with healthcare professionals including GPs both before and after the period of misconduct.

The testimonials describe in detail the elevated level of professional competence and dedication including during the COVID-19 pandemic that Mr Aggarwal demonstrated and many testimonials gave personal recollections of specific incidents where Mr Aggarwal had performed his professional duties at the very highest level and with conspicuous attention to patient safety.

The Committee noted that the very high standards attested to by the character references did not translate to Mr Aggarwal's conduct in respect of online dispensing. The Committee noted one testimonial reflected a common theme to the effect that Mr Aggarwal "*...still has a lot to contribute to the profession and local community...*"

Mrs Aggarwal relied upon 17 character references that also included professional colleagues and members of the public. She also provided testimonials from her family including her daughter and husband. Collectively these testimonials spoke of her compassion and kindness and thorough commitment to the profession of pharmacy. A number of specific examples were provided demonstrating these qualities. Many of the testimonials refer to the shock and confusion on hearing of the allegations against Mrs

Aggarwal and how these were at odds with their understanding and personal experience.

201. The Committee found that there is an obligation when a pharmacy business expands into novel and unfamiliar areas to ensure that proper checks and balances are maintained to keep pace with the changes. In this case the pharmacy business moved into areas that were unfamiliar to the Registrants. They placed an over reliance on the assurances of others without obtaining sufficient evidence that those others could be fully relied upon and without exercising adequate checks of their own. As the business diverged from the orthodox model that the Registrants were accustomed to, they found themselves in a situation where they had overreached their own abilities. The requisite robust scrutiny was absent and the Registrants placed their patients in an extremely dangerous situation.
202. The Committee first considered the option to take no action. This case is too serious to warrant such an outcome given the ongoing risk to the public and the overarching public interest issues.
203. Next the Committee considered issuing the Registrants with a Warning. The Committee found that this was not appropriate given the finding of a continuing risk to patients.
204. The Committee next considered the imposition of conditions of registration. A condition of registration Order would allow the Registrants to practise albeit with restrictions. The Committee must determine whether a conditions of registration Order would be appropriate given the concerns identified regarding the Registrant's practice, in particular whether conditions would protect the public from harm, be sufficient to mark the seriousness of the matter so as to maintain public confidence in the Registrant, the profession and the regulator, and sufficient to promote professional standards within the profession. Conditions must be relevant and proportionate to the concerns identified regarding the Registrants' practice. Conditions must be workable and susceptible to being monitored. The Committee must also be satisfied that the Registrant will comply with any conditions imposed.
205. The Committee considered that, in respect of all Registrants, such an order would not be sufficient to mark the seriousness of the misconduct found proved. Public confidence in the pharmacy profession would not be maintained given the seriousness of the misconduct if such an order were imposed as an outcome. The Committee noted that Mr Haycroft had submitted that such an order would be appropriate in the circumstances but the Committee did not agree.
206. 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.”

207. The Committee concluded that this case is one that demands no lesser an outcome given the risk to patient safety and the requirement to uphold confidence in the pharmacy profession. The question for the Committee was whether this outcome was sufficient and proportionate in the circumstances. Mr Haycroft submitted on behalf of his clients that the outcome of removal from the register should be reserved for only the “*most serious conduct*” as set out in the *Good Decision-making Guidance* and pointed out that this case did not involve dishonesty which is often present in cases that justify removal from the register. The Committee was of the opinion that the misconduct in this case, although not representing the very worst conduct possible, was serious enough that the outcome of removal could potentially be justified.
208. However, the Committee concluded that the absence of any financial motive and no issues regarding the integrity of Mr Aggarwal and Mrs Aggarwal satisfied the Committee that the more serious outcome of removal could be avoided. The maintenance of the reputation of the profession required that the Committee impose an outcome that properly highlighted to the profession and to the general public that the misconduct was so serious and unacceptable that public confidence in the profession could only be upheld by the imposition of, at the very least, a suspension.
209. The Committee concluded that the appropriate and proportionate outcome for Mr Aggarwal and Mrs Aggarwal fell just short of removal. The public interest includes the retention of otherwise competent pharmacists serving their community and the testimonials provided to the Committee evidenced that both Registrants were able to call upon a large number of representatives from both their personal and professional communities to confirm that they were held in high regard. The Committee was satisfied that this was not a case of wilful neglect and there was some mitigation in that the area of online dispensing was new and developing. The positive steps taken by Mr Aggarwal and Mrs Aggarwal since the period of misconduct was a particularly strong factor militating away from the necessity of removal from the register.
210. The Committee noted the submissions made by Mr Haycroft and Mr Hoskins in relation to the respective culpability of Mr Aggarwal and Mrs Aggarwal. The Committee acknowledged that Mrs Aggarwal was involved for a shorter period of time but her role was that of a Superintendent Pharmacist and that brought with it greater culpability. Mr Aggarwal, on the other hand, engaged in the lesser role of a Responsible Pharmacist but his involvement was for a greater period of time and he moved from one flawed dispensing model to another. In the Committee's view the

difference in culpability was negligible between Mr Aggarwal and Mrs Aggarwal and therefore concluded that there should be no difference in the length of the suspension.

211. For the reasons set out above, the Committee was of the view that the misconduct in this case was very serious and placed patient safety in jeopardy. Only the longest period of suspension would be appropriate and therefore the Committee imposes a suspension of 12 months' duration in respect of Mr Mukesh Aggarwal and Mrs Sonia Aggarwal.
212. The Committee then considered the matter of Mr Bassi. His role was similar to that of Mrs Aggarwal in terms of his statutory role as Superintendent Pharmacist although the period of time in which he was in that position was significantly longer. However, the aspect of Mr Bassi's case that concerned the Committee the most was his admission that he took the role of Superintendent Pharmacist in name only and that he performed few, if any, of the duties expected of a Superintendent Pharmacist. The Committee was careful when considering Mr Bassi's admissions to place appropriate weight on that evidence. Mr Bassi, whilst accepting that he did not perform the role required of him, also implicated Mr Aggarwal as being complicit in this arrangement. The Committee noted that Mr Aggarwal did not accept this suggestion and that Mr Bassi could not be challenged on this evidence as he did not attend the hearing to give oral testimony.
213. The Committee accepted the self-incriminating aspects of the statement of Mr Bassi but did not place any weight on the aspects of his statement that suggested Mr Aggarwal was complicit.
214. As set out at stage 2, the Committee found Mr Bassi's misconduct to have undermined his integrity. The Committee also found that this represented an attitudinal defect in Mr Bassi's approach to his statutory function as a Superintendent Pharmacist that would be difficult, if not impossible, to remediate. None of Mr Bassi's written representations came close to providing the Committee with any comfort that Mr Bassi recognised his attitudinal shortcomings such that there was any possibility that they could be addressed in the future.
215. The Committee found that Mr Bassi had placed himself in a different category of culpability to the other Registrants. The wilful neglect of his statutory role as Superintendent Pharmacist was a significant contributory factor that allowed the defects and flaws within the dispensing system to go unchecked. The abrogation of his professional duties was truly shocking and fundamentally incompatible with being a registered pharmacist.
216. It is a personal tragedy for Mr Bassi that he has ended a long and unblemished career in this way but the Committee has concluded that it has no option other than to remove Mr Bassi from the GPhC register.
217. The Committee therefore directs that the Registrar;

- a. suspend Mr Mukesh Aggarwal from the register for the period of 12 months.
- b. suspend Mrs Sonia Aggarwal from the register for the period of 12 months.
- c. remove Mr Amarjit Singh Bassi from the register.

Review Hearing

218. This decision will be reviewed by the Committee before the suspension expires. A future Committee may be assisted by:
- Further reflections concerning the formalisation of the structures within pharmacies to include the roles of SI and the management of potential conflicts of interests

Decision on Interim Measures

219. Mr Hoskins applied for interim measures to be imposed in respect of each Registrant in accordance with Rule 31 and Article 60 of the Pharmacy Order 2010 on the basis that both such measures were required to protect the public and in the public interest citing the Committee's finding of ongoing risk to the public and the shock that the findings of the Committee would cause to a member of the public.
220. Mr Haycroft opposed the application submitting that Mr Aggarwal and Mrs Aggarwal had been working for the last 6 or 7 years without restriction or incident and that interim measures would have a disproportionate and immediate effect on their financial situation. Neither had worked in online dispensing during that period.
221. The Committee received guidance from the Chair, which it accepted, that the Committee may impose interim measures if it is satisfied that the measures are necessary to either protect the public or are otherwise in the public interest or in the interests of the professionals themselves. Interim measures will take immediate effect and can cover the 28-day appeal period.
222. The Committee is satisfied that it is necessary for interim measures to be in place for all Registrants. The findings of the Committee raise enduring public safety issues that necessitate immediate action and the public interest requires interim measures given the widespread concern regarding online dispensing within fundamentally flawed systems that placed large numbers of the public at risk.
223. This concludes the decision.