

General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote videolink hearing

24 June 2026 – 2 July 2026

Registrant name:	Jitendra Desai
Registration number:	2048785
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Manuela Grayson (Chair) Jignesh Patel (Registrant member) Joanne Hird (Lay member)
Committee Secretary:	Ivana Raimundova, Adam Hern
Registrant:	Not present and not represented
General Pharmaceutical Council:	Gareth Thomas, Case Presenter
Facts proved:	2.1, 2.2, 2.3, 3.1, 3.2 – including Schedule A
Facts not proved:	1.1, 1.2
Fitness to practise:	Impaired
Outcome:	Suspension Order for a period of 12 months
Interim measures:	Interim measure of suspension imposed

This decision including any finding of facts, impairment and sanction 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 31 July 2026 or, if an appeal is lodged, once that appeal has been concluded. However, the interim suspension set out in the decision takes effect immediately and will lapse when the decision takes effect or once any appeal is concluded.

Particulars of Allegation (as amended)

“You, a registered pharmacist, being the Responsible Pharmacist at Oakley Pharmacy, 270 Telegraph Road, Heswall, Wirral CH60 7SE (“the pharmacy”),

1. Between January 2023 and October 2023, failed to:

1.1 keep an up-to-date Responsible Pharmacist record

1.2 have in place and/or keep up to date a controlled drugs register when you knew or ought to have known that the pharmacy was dispensing controlled drugs

[NOT PROVED]

2. On or around 27 September 2024, you attended work whilst unfit in that you:

2.1 slurred your speech;

2.2 were unsteady on your feet;

2.3 had consumed alcohol.

[PROVED]

3. On, or around 12 December 2024, disposed of an unknown quantity of medication and confidential pharmacy waste detailed in Schedule A, in an unsafe manner in or around Beacon Park, Heswell, Wirral Council in that you:

3.1 failed to de-nature the medications or otherwise render them safe prior to disposal

3.2 discarded the medication and / or confidential pharmacy waste in waste bags.

[PROVED]

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

Schedule A

1. Mr W GPhC Inspector business card – exhibit CW/03

2. E-mail print out between Ms Islam, GPhC Case Officer and the Registrant – exhibit CW/04

3. Four pages of near miss records – exhibit CW/05 to CW/07

4. 1 x Eumovate cream tube;

5. 1 x Ketoconazole cream tube;
6. 1 x Hydrocortisone cream tube;
7. 21 x Nicorette 4mg gum;
8. 15 x Piriton 4mg tablets;
9. 19 x Finasteride 1mg tablets;
10. 4 x Loratadine 10mg tablets;
11. 20 x Amoxicillin 500mg capsules;
12. 13 x Flucloxacillin 500mg capsules;
13. 17 x Omeprazole 20mg capsules;
14. 4 x Zolpidem 10mg tablets;
15. 7 x Lorazepam 2.5mg tablets”.

Documentation

At Stage 1 (Facts):

Document 1- GPhC hearing bundle, 183 pages

Document 2- Additional Bundle, 21 pages

Document 3- GPhC skeleton argument, 14 pages, dated 17 June 2026

Document 4- Proof of Service bundle, 7 pages

Document 5- Proceeding In Absence bundle, 21 pages

Document 6- Notice of hearing dated 13 May 2026

Document 7- Bundle of documents received on first day of hearing including emails from Registrant dated 23 and 24 June 2026; two medical Fit notes from Registrant; file note of Committee Secretary, Ms Raimundova, dated 24 June 2026

Document 8- 24 June 2026 email sent to Registrant by Committee Secretary informing him that the hearing would proceed in his absence

Document 9- bundle of documentation provided by the Council on 29 June 2026, including documentation from Council's register; from Companies House; emails from the Registrant demonstrating which CD register records were attached.

At Stage 2 (Impairment):

Documents 10, 11 and 12: FTP Committee Determination from September 2019 (Principal Hearing); FTP Committee Determination from March 2023 (Principal Hearing Review); FTP Committee Determination from May 2025 (Interim Order Review).

At Stage 3 (Outcome):

Document 13: Documentation about the Warning imposed by the Investigating Committee in 2012

Witnesses:

Dr M, then GP Partner, Myrtle Group Practice

Dr W, GP Partner, Myrtle Group Practice

Ms K, then Practice Manager, Myrtle Group Practice

Mr L, then GPhC Inspector

Mr O, then locum pharmacist, Oakley pharmacy

Mr W, GPhC Inspector, pharmacist

Determination

Introduction

1. This is the written determination of the Fitness to Practise Committee at the General Pharmaceutical Council ('the Council').
2. The 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 or sanction should be applied if the Registrant's fitness to practise is found to be impaired.

Service of Notice of Hearing

6. The Committee was provided with the Council's "Proof of Service" bundle. It contained a letter dated 13 May 2026 from the Council headed 'Notice of Hearing' addressed to the Registrant. The Committee observed evidence in the bundle which showed that the Notice was sent to the Registrant's email address as it appears on the register, and that the Registrant had consented to documentation being sent by the Council to his registered email

address. The Committee was satisfied that there had been good service of the Notice in accordance with Rules 3 and 16.

Application to Proceed in the Absence of the Registrant

7. The Registrant was not in attendance at this hearing, nor was someone attending on his behalf.
8. The Committee heard submissions from Mr Thomas on behalf of the Council, to proceed in the absence of the Registrant in accordance with Rule 25, and with relevant case law including the case of GMC v Hayat [2018] EWCA Civ 2796. Mr Thomas informed the Committee that the Registrant had not been in contact with the Council at all for about a year until about 10pm on the evening of 23 June 2026, when the Registrant wrote to the Committee Secretary, Ms Raimundova, in response to her email to him containing the link for this remote hearing.
9. Mr Thomas submitted that the Registrant could have engaged with these proceedings at any time before that but had not done so.
10. Mr Thomas further submitted that there are at least six witnesses warned to take part in the hearing, plus three others who may be called to give evidence, and all other arrangements, for example convening the Committee, had been made for this listing. There was a public interest in proceeding with the case as listed and the regulator's overarching purpose, namely public protection and protection of the public interest should be borne in mind by the Committee when making its decision whether to proceed. Mr Thomas also drew the Committee's attention to the principles set out in the above case of Hayat regarding the weight which can be given to GP fit notes.
11. The Committee considered all of the evidence relevant to whether it should proceed in the Registrant's absence.

12. Evidence within the Council's Proceeding in Absence bundle showed that after some reminding from the Council, in early 2025, the Registrant had provided signed consent documentation so that the Council could (REDACTED) but would respond that afternoon or the following day, and thereafter he ceased to engage with the process.
13. The evidence showed that all post in connection with this hearing sent to the Registrant's registered postal address was returned unopened; 'egress' emails sent to his registered email address were not accessed; and those and other non-security-controlled emails were not responded to. Private investigators were engaged by the Council twice during the investigation period, to ascertain whether the Registrant was still living at the registered address.
14. The Registrant did not engage with the process after June 2025 until the email referred to above, sent around 10pm on 23 June 2026.
15. The Committee had agreed to delay the start of the hearing on 24 June 2026 so that Mr Thomas and/or the Committee Secretary Ms Raimundova could speak to the Registrant to ascertain his position with regard to whether to proceed, and whether he wished to take part.
16. The Committee was shown a file note prepared by Ms Raimundova following her phone call with the Registrant on the morning of 24 June 2026. Ms Raimundova recorded as follows:

"I asked him if he had any implication (REDACTED)
I asked [him] whether he would like to attend in the future i.e. request a postponement but he didn't know when he could attend".
17. The Registrant said he had not accessed any documentation and had not seen the Particulars of Allegation. Ms Raimundova suggested he speak to Mr Thomas.

18. Following his conversation with Mr Thomas, in which, Mr Thomas told the Committee, the Registrant said (REDACTED) and could not take part in the hearing, the Registrant sent the following email message at 11.22:

“(REDACTED)”.

19. (REDACTED)

20. In an email timed at 12.40 on 24 June 2026, the Registrant wrote to Mr Thomas in the following terms:

“I would just like to say that all the allegations were due to (REDACTED)”.

21. Having fully taken into account the contents of the Council’s Proceeding in Absence bundle, and all of the further evidence of recent communications with the Registrant summarised above, the Committee decided to proceed with the hearing in the absence of the Registrant for the following reasons:

- The Committee has found good service of notice and the Registrant is aware of today’s proceedings.
- The evidence before it is that the Registrant has engaged erratically at best with these regulatory proceedings: he ceased communication in around June 2025; all attempts to engage with him since then had been unsuccessful until he contacted Ms Raimundova, the Committee Secretary, late on the evening before the hearing was due to commence.
- The Committee considered (REDACTED)
- The Committee considered (REDACTED)
- Whilst the Registrant had also stated that a postponement would give him time to “prepare [his] case” or “(REDACTED)” the Committee was bound to observe that he had had ample opportunities over the year to access the documentation sent to him both by registered post and by secured encrypted email, and then to engage with the

process and prepare his case, but he had not done so. He had told the Committee Secretary that he had not even read the Particulars of Allegation.

- It appeared to the Committee, after carefully considering the recent communications with the Registrant, that although he had, on the morning the hearing was due to commence, made a request for a three- month postponement, he had been unable to provide any independent evidence to suggest that (REDACTED).
- The Committee is of the view, taking all of the above into account, that it cannot be assured that postponing the hearing and arranging a new listing in future would result in the Registrant's attendance.
- There were six witnesses ready to provide live evidence; and three more on stand- by who might be required as well; postponement on the first day of the listing with the expectation that they will be asked to participate at a future date could cause them considerable inconvenience.
- The allegations were serious and date from alleged events some years ago; given the regulator's overriding purpose as set out above, it is in the public interest for proceedings to take place expeditiously.

22. The Committee appreciated that the Registrant could be disadvantaged by this hearing proceeding in his absence and without representation however the Committee resolved to mitigate any risk by carefully examining any inconsistencies in the Council's case and at all times during its deliberations and during the hearing, bearing in mind that the Registrant is absent.

Applications on behalf of the Council to amend the Particulars of Allegation

23. At the start of the hearing, the Committee heard an application from Mr Thomas on behalf of the Council under Rule 41 to amend the Particulars of Allegation by adding the following:

"2.3: had consumed alcohol".

24. Mr Thomas submitted that the Registrant had been notified of the Council's intention to amend the Allegation as above by email on 10 June 2026, but he had not responded. Mr

Thomas submitted that the amendment would not be unfair to the Registrant but would better particularise the facts.

25. Mr Thomas reminded the Committee that whilst fairness to the Registrant was important, there was also a duty to be fair to the regulator and the wider public interest.
26. The Committee was of the view that the Registrant had been given sufficient notice of the proposed amendment. It agreed that there was some evidence which it would need to assess in due course in relation to whether the Registrant had, on the relevant date, consumed alcohol. It was satisfied that this amendment would not prejudice the fairness of the proceedings.
27. Accordingly, the Committee accepted the amendment to add the Council's proposed particular 2.3 to the Particulars of Allegation proposed on the behalf of the Council.
28. After the evidence on behalf of the Council had been heard and before closing his case in relation to the facts, Mr Thomas made a further application to amend the Particulars of Allegation. He submitted that on the basis of all of the evidence now available, the Council was not in a position to sustain an argument that the Registrant was the owner of the Pharmacy. He provided a further bundle of evidence on behalf of the Council including screen shots from the Council's database, evidence from Companies House, and various evidence from witnesses. He submitted that although the evidence was that a number of people, including some employed at the Pharmacy and also staff who worked next door at the GP surgery thought or assumed that the Registrant owned the Pharmacy, this could not be demonstrated in any documentation.
29. Mr Thomas submitted that it would better reflect the evidence therefore to delete

"Owner and"

from the stem or preamble of the Allegation. He submitted that this would have the overall effect of reducing the gravity of the allegations so would not unfairly prejudice the Registrant.

30. The Committee had regard to Rule 41 which allowed for it to amend the particulars “at any stage before making its findings of fact”, unless it was of the view that the required amendment would prejudice the fairness of the proceedings. Having carefully considered the evidence available, the Committee agreed that this amendment better reflected the available evidence as to whether the Registrant was the “owner” of the Pharmacy, and it considered that the amendment would be likely to have the overall effect of diminishing the gravity of the concerns raised against the Registrant. For these reasons the Committee was satisfied that the proposed amendment would not prejudice the fairness of the proceedings, and it therefore accepted Mr Thomas’s application to amend the Particulars of Allegation in the manner he requested.

Application for Some Parts of the Hearing to be heard in Private

31. Mr Thomas made an application for parts of the evidence to be heard in private under Rule 39 of the Rules. He submitted that this was unlikely to be necessary in connection with particulars 1 and 3 of the Allegation but might be relevant when evidence and submissions were to be heard in connection with particular 2.
32. The Committee took into account that subject to exceptions, Rule 39 requires that hearings of the Committee must be heard in public. However, by Rule 39(3) (b), a hearing may be heard wholly or partly in private if the Committee “is satisfied that the interests of the [Registrant] in maintaining their privacy outweighs the public interest in holding the hearing, or part of the hearing, in public”.
33. It was of the view that it would be appropriate, if reference to the Registrant’s health is made during the hearing, for those parts of the hearing to be heard in private.

Informing the Registrant of the Committee's Decision to Proceed

34. After the Committee decided to proceed with the hearing, and preliminary matters including whether to hear health matters in private had been decided, the Committee Secretary wrote to the Registrant in the following terms:

"Dear [Registrant],

The Committee has made a decision not to postpone and the hearing has started and will continue in public except where there is mention of your health – that will be private. I will provide their written decision with reasoning as soon as it becomes available.

If you wish to participate in the proceedings in any way going forward please do let me know.

Otherwise I will keep you updated as best I can.

Thank you".

35. The Registrant made no further contact with the Council thereafter.

Background, according to the Council

36. The allegations reflect three concerns in chronological order. Throughout the period of January 2023 to December 2024 the Registrant worked as the Responsible Pharmacist, at Oakley Pharmacy in Heswell, Wirral ("the Pharmacy").

Allegation 1

37. The Council alleged that the Registrant failed to have in place or keep up to date a Controlled Drugs Register, as required for Schedule 2 controlled drugs, when he plainly knew that such controlled drugs were being supplied by the Pharmacy. There are two sources of information in relation to this allegation.
38. Mr O was a locum pharmacist who sometimes worked at the Pharmacy between January and August 2023. He describes how it became apparent to him that Controlled Drugs Registers were not being kept up to date or at all. He challenged the Registrant about this and threatened to cancel his shifts in March 2023 unless the situation was remedied.

Despite some new software (Pharmsmart) being used on a trial basis, problems with the CD registers persisted and Mr O parted ways with the Pharmacy in August 2023. He produces text exchanges with the Registrant to illustrate how he raised his concerns and the Registrant's responses.

39. The second source of information in relation to CD registers is the Council's (former) Inspector Mr L, who visited the Pharmacy in October 2023. On 9 October 2023 the Pharmacy did not have a CD register available. However, by 11 October 2023 an electronic register had been put in place. Dispensing data for controlled drugs was obtained from the Pharmacy (from the Registrant) by the Council's case officer in March 2024. These records cover the period from January to October 2023. They appear in an Excel workbook with patient identifying data redacted. The data was shown to the Inspector, Mr L, who undertook an audit and reports that *"several hundred supplies were made of Schedule 2 controlled drugs that were not entered into a controlled drug (CD) register as received or supplies, in accordance with the Misuse of Drugs Regulations"*.
40. In an email to the case officer on 18 April 2024, the Registrant replied "no" when asked if he (or any other Pharmacy staff) raised concerns to the then Superintendent in relation to managing controlled drugs and ensuring accurate record keeping of controlled drugs.
41. In his report from the Inspection on 11 October 2023 Mr L also noted that the Responsible Pharmacist log was incomplete *"with several dates between March 2023 and the inspection date having no record to identify the pharmacist in duty when the pharmacy was trading. And there was no RP record available prior to March 2023. This meant the pharmacy was not able to demonstrate who was responsible at specific times"*. Mr L had secured a hard copy of the RP log which was before the Committee. This related to allegation 1.1.

Allegation 2

42. On 27 September 2024, the Registrant was working as Responsible Pharmacist at the Pharmacy. A concern was raised with a GP practice that occupies the same site as the Pharmacy. This led to two witnesses from the surgery (Dr M and Ms K) speaking to the Registrant and observing his presentation. Dr M was a GP partner at the practice. Ms K was the practice manager. They spoke to the Registrant in person, individually and together.
43. According to Dr M, the Registrant had *“appeared drunk was unsteady on his feet when walking round and slurring his words”*. His breath smelt of mints. The Registrant denied that he had been drinking but declined to take a breathalyser test (which the surgery had on site). According to Ms K, when she first saw the Registrant he was *“sat in his chair slumped”*. When questioned about slurring his speech, the Registrant said that he was getting used to (REDACTED). Ms K considered that he looked (REDACTED)
44. (REDACTED)

Allegation 3

45. On 12 December 2024, one of the Council’s inspectors, Mr W, was contacted by a park ranger for Wirral Council (Mr S) about some dumped waste recovered from a park in Heswall. The waste had been collected and moved to a separate location. Mr W attended this site and made a search of the items, which had been stored in a bin. Photographs appear in the bundle, and a list of items is found at paragraph 7 of the Inspector’s statement. These items include zolpidem and lorazepam, which are schedule 4, part 1 controlled drugs. The items also included one of Mr W’s business cards and other material that enabled him to connect the waste with the Registrant’s pharmacy.
46. In addition to this witness evidence, the Council also produces email correspondence between the Inspector and Mr S in which further details and photographs are provided illustrating how the dumped waste came to be found and what condition it was in before

being moved. For completeness, the dumped waste appears to include empty bottles of alcohol. Further email contact took place between Mr s and the Council's case officer.

47. The concerns about pharmacy waste were put to the Registrant by the Council's case officer, by email, on 7 April 2025. In reply on 13 April 2025, the Registrant stated among other things:

"I was responsible for leaving the items in the woods. Unfortunately (REDACTED)."

48. One of the items recovered was a printed email correspondence between the Registrant and one of the Council's case officers. This would further link the Registrant with the actual dumping of the waste. According to Google Maps, the park where the waste was found is less than one mile from the Pharmacy premises (270 Telegraph Road).
49. The Inspector explains in his statement how the controlled drugs had to be taken to a local pharmacy for secure disposal. The recovered waste included other prescription-only drugs (e.g. amoxicillin) which could have been misused if recovered by a member of the public. The waste also included a near miss log with pharmacy staff details.

Registrant's Response

50. The Registrant provided no formal response to the Particulars of Allegation, nor did he provide any evidence in relation to the concerns nor in relation to any insight or remediation.
51. However, the file note of Ms Raimundova, the Committee Secretary, in relation to a phone conversation she had with the Registrant on 24 June 2026, set out that she read him the allegations (as drafted prior to their subsequent amendment at the start of this hearing), because he said he had not read them before, and then:

"I asked [the Registrant] whether he would wish to send any response to the allegations, or attend to address the Committee directly. He said 'No, because they are correct'. I asked whether it means that he would have admitted to those allegations and he said yes".

DETERMINATION ON THE FACTS

52. The Committee then turned to make its determination in relation to the alleged facts in the first instance.
53. In reaching its decisions on facts, the Committee considered the documentation listed at the start of this determination, and the submissions made by Mr Thomas on behalf of the Council. Mr Thomas told the Committee that this was not a case in which it should give itself a “good character” direction – in any case such a direction would only apply to propensity, and not to credibility since there was no significant evidence provided by the Registrant in relation to the concerns.
54. 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.
55. The Committee was of the view that all of the live witnesses did their best to assist the Committee and were open and honest.
56. It noted however that Mr L, the Council’s Inspector at the time, had not appeared to recall, when giving live evidence to the Committee, that he had been copied into emails which the Registrant had sent to the Council attaching extracts of electronic CD registers which were before the Committee. It noted that the Registrant sent the emails with attachments to the Council between 18-24 March 2025, sometime after the two dates on which Mr L attended the Pharmacy, 9 and 11 October 2023, when, according to Mr L, there was no CD register available on 9 October but there was an electronic register present on 11 October 2023.

Particular 1 and the stem of the Allegation

*“You, a registered pharmacist, being the Responsible Pharmacist at Oakley Pharmacy,
270 Telegraph Road, Heswall, Wirral CH60 7SE (“the pharmacy”),*

1. Between January 2023 and October 2023, failed to:

1.1 keep an up-to-date Responsible Pharmacist record

*1.2 have in place and/or keep up to date a controlled drugs register when you knew or
ought to have known that the pharmacy was dispensing controlled drugs*

57. The evidence in support of this allegation included the audit of the Responsible Pharmacist (“RP”) record for the relevant period; the audit of what was available from the digital Controlled Drugs Register for the relevant period together with the Excel spread sheet demonstrating the supply of controlled drugs made by the Pharmacy during that period; and the witness evidence of Mr O who was a locum pharmacist working part time at the Pharmacy.
58. In relation to sub-particular 1.1, the Committee observed that the audit of the RP record for the relevant dates showed that there were a number of dates in which there was no entry at all indicating that an RP was present, although the evidence from Mr L was that the Pharmacy was opened at least five days a week and also possibly at weekends. Moreover, on the majority of occasions set out in the audit, where an RP had registered an entry in the morning, there was no corresponding time entered for when the RP would have terminated their duty on that day. The Committee noted that this absence of an entry showing the time of termination applied not only to entries by the Registrant but also those by the witness Mr O and other RPs.
59. Whilst the evidence suggested that the RP record had not been kept up to date, there was no evidence before the Committee of any instances when the Registrant was in fact present as an RP but had not recorded this. The Committee observed that the Registrant was neither the Superintendent at the relevant time, (he became the Superintendent later on 14

November 2023), nor was he alleged to have been the owner of the Pharmacy. In these circumstances, the Committee was of the view that the Council had not discharged its burden to prove that the Registrant had a professional duty to keep the RP record up to date generally, including in relation to other RPs. Therefore, it could not be said that the Registrant had “failed” to keep an up-to-date Responsible Pharmacist record.

60. The Committee noted, in fairness, that Mr Thomas had made what he called a “realistic concession” in closing submissions on the facts, that the Council’s evidence in support of this allegation was now somewhat weak.
61. The Committee found sub-particular 1.1 not proved.
62. As for sub-particular 1.2, the Committee carefully considered the evidence. Mr Thomas had submitted that the evidence was from two main sources: Mr L who inspected the Pharmacy in October 2023; and Mr O who was a locum pharmacist for some of the relevant time.
63. Mr L had stated in his Investigation Report of 11 October 2023 that the Superintendent had resigned on 23 September 2023, and the Pharmacy was operating without a nominated superintendent. His evidence from the inspection was that there was evidence that Schedule 2 controlled drugs were being dispensed and supplied by the Pharmacy but were not entered into CD registers as was required by law. Staff at the Pharmacy were unsure whether the CD registers were being kept up to date and it appeared that they thought the Registrant was responsible for doing so.
64. The Inspection Report recorded that:

“At the time of inspection, an electronic CD register was in place and entries had been made for four strengths of Methylphenidate XL. But no other electronic CD records had been made”.

There were also some old paper records dating from April 2021.

65. The Committee noted however that Mr L's Inspection report had been written in October 2023, some months before March 2024 when the Registrant had sent a number of electronic CD records to the Council, copying Mr L in.
66. Taking the above into account, and having heard Mr L's live evidence, the Committee was not satisfied that he had taken account of the CD records sent in by the Registrant in March 2024, when he came to the conclusion that the records were not kept up to date. He did not appear to recall seeing those records, when asked about them in live evidence. The Committee could not therefore rely on Mr L's assessment of the state of the CD recording as set out in his Inspection Record.
67. As for the evidence of Mr O, there was clear documentary evidence in the form of messages on text that Mr O was concerned about the lack of CD record-keeping whilst he was working at the Pharmacy as a locum between March and August 2023. He told the Committee that he asked the Registrant informally a number of times, to deal with his concern, but later he decided to be more formal and record his concerns in texts. He would receive repeated assurances from the Registrant that the matter was being dealt with.
68. For example, in March 2023, the following exchange took place:

20 March 2023

"Hi [Registrant's name], I thought I'd text to confirm what we spoke about earlier. If I arrive at Oakley tomorrow and the CD balance check is not complete (accurate balances, all all CDRx entered etc) I will not be starting the shift, I won't open the shop [...] Any problems with that let me know".

20 March 2023, 21.45:

"Buddy it's being done pal still here"

21 March 2023, 6.51:

"Morning [Registrant's name], how did you get on? is everything entered?"

“Hi pal, I’m here again finishing off so will be in the next hour just had to get Pharmsmart reset again last night”.

69. Mr O told the Committee that the Registrant appeared to be using a series of free trial periods offered by the software company to record CDs, perhaps by using different email accounts. When a free trial period ended, there would be a hiatus of a few days in which there was no electronic CD record in place, and then it would start up again. When asked whether he ever found he was making a first entry in a system, suggesting that there had been no recording in his absence, Mr O said this was not the case: the record would have been started up and been in use in his absence when there was a different RP on duty. Mr O told the Committee that he was led to believe from all the circumstances at the Pharmacy that the Registrant was the owner, and it was his clear impression that the Registrant accepted the responsibility for keeping the CD records up to date. Both he and another pharmacist interviewed by Mr L said that the Registrant would tell them to put CD prescriptions and invoices in a basket on the side instead of making the CD record entries themselves, and he told them that he would deal with them later. Mr O told the Committee that the Registrant would come into the Pharmacy in the evenings and at weekends to catch up on work, including CD recording.

70. The Committee was taken by Mr Thomas to an email from the Registrant on 18 March 2024, responding to queries from the Council’s case officer about the management of CDs at the Pharmacy. When asked how the then Superintendent had managed the Pharmacy, the Registrant replied “remotely”. The email continued:

“What responsibilities did Mr SL have as the superintendent? All expected of a Superintendent.

How often did Mr SL visit the pharmacy? Twice monthly

[...] What responsibilities did Mr SL have in relation to managing controlled drugs and ensuring accurate record keeping of controlled drugs? I assume it was left to me

Did you and or any other pharmacy staff raise any concerns to Mr SL about the management and recording of controlled drugs and any evidence of this? No
What did Mr SL do to assess, record and manage risks within the pharmacy and any evidence of this? Cannot answer this
What responsibilities did Mr SL delegate to others? None to my knowledge”.

71. Mr O finally stopped working locum shifts at the Pharmacy in August 2023 because he was so concerned about the situation regarding CD recording, and he made a referral to the Council.
72. Taking all of the evidence into account, it appeared to the Committee that the CD recording at the Pharmacy during the period Mr O worked there, was no doubt haphazard and chaotic; and it appears likely that matters did not improve much after he left – for example no CD record could be found when Mr L attended on 9 October 2023, and the CD records he was shown on 11 October were, he considered, incomplete. The Committee was told that the Superintendent resigned in September 2023 and for a time there was no superintendent in place at all.
73. However, given that the Registrant did send in some CD records after the Inspection report was completed, and a further tally with the record of CD supplies was not provided to the Committee to demonstrate that the records were not up to date, the Committee was of the view that the Council had not discharged its burden to prove that the CD records were not in fact kept up to date.
74. More fundamentally, while much of the evidence before the Committee suggested that the Registrant appeared to have taken on operational responsibility for maintaining the CD records, given that he was not the Superintendent and the Council does not allege that he was the owner, the Committee was not satisfied that he in fact had a duty to maintain the records except on the days he was on duty by virtue of being the RP on those days. There was insufficient evidence before the Committee that he breached that duty.
75. The Committee therefore found sub-particular 1.2 not proved.

Particular 2

2. On or around 27 September 2024, you attended work whilst unfit in that you:

2.1 slurred your speech;

2.2 were unsteady on your feet;

2.3 had consumed alcohol.

76. The RP record before the Committee confirmed that the Registrant was on duty on 27 September 2023 as RP. The evidence in support of this particular included the witness evidence of Dr M, Dr W and Ms K, the GP Practice Manager.

77. The Committee was of the view that the evidence of Dr M and Ms K was cogent and could be relied on. It was consistent and detailed and set out a credible version of events on the day.

78. As for the evidence of Dr W, whilst the Committee did not doubt the truthfulness of her evidence, it did not place weight on it because she had seen the Registrant purchasing the bottle of vodka “two weeks prior” to the date of this allegation. It was during his lunch hour. There was no evidence before the Committee that the Registrant attended work whilst unfit on that day.

79. Dealing first with the concerns set out at 2.1 and 2.2, the Committee took into account that following a concern raised by a patient, and Ms K’s notification of this to Dr M both she and Dr M then went to speak to the Registrant. They walked with him to the GP surgery to have a chat. Both observed the conduct described in these particulars: Dr M stated that “he was slurring his words...unsteady on his feet when walking round and slurring his words”. Ms K stated that

“whilst he was talking to me he was slurring his words, telling me everything was all ok...his walking was all over the place and he was not walking in a straight line”.

80. Not only was he slurring his speech and unsteady on his feet, but also, Ms K said, he was “sat in his chair slumped...he looked dishevelled...he just did not look himself”. The concern had been raised by a patient who reported, according to Dr M, that he “appeared drunk in the Pharmacy”. The Committee was satisfied that whatever the cause (alleged at 2.3), the Registrant’s demeanour was such that it could conclude that the Registrant attended work whilst unfit.

81. On the basis of the evidence from the two witnesses above, the Committee found the preamble and sub-particulars 2.1 and 2.2 proved.

82. Turning to 2.3, the Committee had before it conflicting evidence. The Registrant was reported to have told his staff that he had taken co-codamol; and alternatively, that he was getting used to some new medication. The Pharmacy’s Incident Report recorded that on returning from lunch, the Registrant

“appeared to be a little distressed. When asked he said he had just fallen over outside and hurt himself. He said he was going to rest in the office for a while. When he came out of the office a while later he appeared to be unsteady on his feet and he said he had taken some strong painkillers”.

83. Mr Thomas told the Committee that according to a Council file note, on 2 October 2023, the Registrant had told another GP, Dr N at the Myrtle Practice that he had taken co-codamol (REDACTED); she did not think he was intoxicated on 2 October 2023.

84. Ms K’s evidence in her witness statement was that

“to me he was definitely under the influence of something, whether it was alcohol or another substance...to me, (REDACTED)”

She repeated the same in live evidence – she was not sure what the substance was, but he definitely appeared “under the influence of something”. She did not smell alcohol on his breath.

85. Whilst the patient thought the Registrant was drunk, and Dr M stated that the Registrant “certainly appeared drunk”, he did not smell alcohol on his breath – Dr M said he smelt mints.
86. The Registrant agreed to leave work early at the request of Dr M, and Dr M then stayed to ensure the Pharmacy was closed early.
87. The Registrant declined to take a breathalyser test which Dr M offered, so there was no independent evidence that alcohol was the cause of the behaviour observed by the witnesses.
88. In addition to the above evidence, the Committee took into account the evidence before it that the Registrant had informed the Council in a phone call on the first day of the hearing that his conduct as alleged was due to (REDACTED)
89. In an email timed at 12.40 on 24 June 2026, dealing with whether the hearing would proceed as listed, the Registrant wrote to Mr Thomas in the following terms:

“I would just like to say that all the allegations were due (REDACTED)”

90. The Committee also took into account an email dated 13 May 2025 sent by the Registrant to the Council’s case officer in response to queries about the objects found in the local park (described at particular 3). The Registrant wrote as follows:

[REDACTED].

91. In addition, the Committee was also shown an extract from a Committee’s determination in a separate matter at a hearing which the Registrant attended, which set out that:

[REDACTED]

92. Having considered all of the evidence before it in relation to sub-particular 2.3, the Committee was satisfied that it was more likely than not, on the basis of the direct witness evidence of his demeanour at the time, and of his apparent admissions as to his use of alcohol at the time, that the Registrant was unfit for work and had consumed alcohol on 27 September 2023.
93. The Committee found sub-particular 2.3 proved.

Particular 3

3. On, or around 12 December 2024, disposed of an unknown quantity of medication and confidential pharmacy waste detailed in Schedule A, in an unsafe manner in or around Beacon Park, Heswell, Wirral Council in that you:

3.1 failed to de-nature the medications or otherwise render them safe prior to disposal

3.2 discarded the medication and / or confidential pharmacy waste in waste bags.

94. The evidence in support of particular 3 included photos of numerous waste bags in a park and of their contents; the hearsay evidence from the park ranger; and the evidence of Mr W. It also included the following correspondence between the Council's case officer and the Registrant:

Email 7 April 2025:

"Dear [Registrant],

The GPhC received a concern that rubbish bin bags containing half empty blister packets were found discarded at a public park in Heswall on the Wirral, Merseyside. Within the contents was the business card of the GPhC inspector, 4x near miss logs containing the names of staff members at Oakley Pharmacy...and a printout of an email thread between you, the

Superintendent Pharmacist at the time, and [a GPhC case officer]”. Questions as to the Registrant’s potential involvement were then set out in the letter.

95. The Registrant responded in an email dated 13 May 2025 as follows:

“Sorry for the late response. I was responsible for leaving the items in the woods. [REDACTED.

96. Mr W explained that the medications found, though they were not CDs which required CD safe disposal, ought nevertheless to have been disposed of safely in accordance with the regulations which require them to be properly removed from a pharmacy by licensed waste disposers. He told the Committee that having been given the medications he took them to another pharmacy nearby for appropriate disposal and the pharmacist signed a receipt as required to prove safe handover.

97. The Committee was satisfied on the basis of the above evidence that particular 3 was proved in its entirety.

THE COMMITTEE’S DECISION ON GROUNDS AND IMPAIRMENT

98. Having found particulars 2 and 3 proved in their entirety, the Committee then went on to the second stage of the proceedings, that is, to determine whether or not the Registrant’s fitness to practise is currently impaired. It took into account the relevant law including case law and also took into account the submissions of Mr Thomas on behalf of the Council.

99. Article 54(1) of the Pharmacy Order 2010 provides:

“The Fitness to Practise Committee must determine whether or not the fitness to practise of the person in respect of whom the allegation is made (referred to in this article as “the person concerned”) is impaired”.

100. The Council has set out the meaning of ‘fitness to practise’ in its guidance entitled: “Good decision-making: Fitness to practise Hearings and Outcomes Guidance” (Revised March 2024). Paragraph 2.12 states:

“2.12 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.”

101. Consideration of impairment is undertaken in two stages. First, the Committee has to consider whether, on the facts found proved, there has been misconduct. It then has to consider whether, as a result, the Registrant’s fitness to practise is currently impaired. This approach was outlined by Mr Justice Cranston at paragraph 19 of Cheatle v GMC [2009] EWHC 645 (Admin):

“A Panel must engage in a 2-step process. First, it must decide whether there has been misconduct, deficient professional performance or whether the other circumstances set out in the section are present. Then it must go on to determine whether, as a result, fitness to practise is impaired. But it may be that despite a [practitioner] having been guilty of misconduct, for example, a Panel may decide that his or her fitness to practise is not impaired.

Evidence at Stage 2

102. Mr Thomas submitted that at this stage it was appropriate to inform the Committee about the Registrant’s previous regulatory history. He provided the Committee with the following documents:

- FTP Committee Determination from September 2019 (Principal Hearing)
- FTP Committee Determination from March 2023 (Principal Hearing Review)
- FTP Committee Determination from May 2025 (Interim Order Review).

103. The documentation showed that at a Principal Hearing in September 2019, the Registrant admitted that he had, in 2017, attended work as a Responsible Pharmacist whilst unfit to do so and that he (REDACTED). The Committee went on to determine that the Registrant's fitness to practise was not impaired by reason of his misconduct but remained impaired due to (REDACTED). The Conditions were renewed and extended twice and then, in March 2023, the Registrant was restored to the register unrestricted.
104. In May 2025 the Registrant attended an interim order review in relation to the current concerns. The Committee's determination sets out that on that occasion the Registrant said "(REDACTED)"

Submissions on behalf of the Council

105. Mr Thomas referred the Committee to the relevant law and to his skeleton argument. He submitted that it would be helpful to this Committee for it to take into account what was contained in the previous determinations, in order to gain a broad understanding of the Registrant's previous regulatory history. He submitted that it can be seen from the above documentation that although this case is brought by the Council on the ground of misconduct, there is a background of (REDACTED.)
106. He submitted that the Registrant breached a number of professional standards, that his conduct found proved would attract a degree of opprobrium and amounted to serious professional misconduct. There was almost nothing from the Registrant before the Committee in relation to any insight or remediation in relation to the current concerns save for his recent admissions in relation to (REDACTED); and the Registrant's past history suggested that the risk of repetition was higher than if the current matters were isolated. In the absence of any proper explanation or apology, particularly in relation to the Registrant's conduct at particular 3, members of the public would be shocked if a finding of impairment were not made.

The Committee's Decision

Grounds

107. Article 51(1) of the Order set out the possible grounds or “gateways” to a finding of impairment. The relevant gateway in this matter is:
- “misconduct” (Article 51(1)(a)).
108. The Committee turned to consider whether the facts it had found proved amount to the ground of misconduct.
109. The Committee first considered the facts proved in light of the Council’s Standards for Pharmacy Professionals (May 2017).
110. It was of the view that the Registrant breached the following Standards:
- Standard 5 – Pharmacy professionals must use their professional judgement
 - Standard 6 – Pharmacy professionals must behave in a professional manner
 - Standard 7 – Pharmacy professionals must respect and maintain a person’s confidentiality and privacy
 - Standard 8 – Pharmacy professionals must speak up when they have concerns or when things go wrong
 - Standard 9 – Pharmacy professionals must demonstrate leadership
111. Dealing first with the Registrant’s proven conduct at particular 2, the Committee considered that the Registrant failed to use his professional judgement and to work in a professional manner, by attending work whilst unfit, and having consumed alcohol, instead of removing himself from the pharmacy workplace or seeking help. His conduct in attending work whilst unfit to do so struck at the core of the fundamental responsibility of a pharmacist to ensure he can safely and effectively carry out his responsibilities, which, on 27 September 2024, given the evidence of witnesses, the Registrant would have been quite unable to do. Whilst there was no evidence that he had in fact made errors on duty,

it was, the Committee considered, extremely irresponsible of the Registrant to attempt to work whilst unfit; and particularly so given his previous regulatory history. This was not the first time the Registrant had been at work whilst unfit, having consumed alcohol, and so he should have been well aware of the professional implications and the implications for patient safety of doing so. The fact that he was in a position of seniority as RP made such conduct even more serious; he failed to show leadership and he failed to speak up when things were going wrong.

112. Turning to the Registrant's conduct at particular 3, the Committee accepted the submissions of Mr Thomas to the effect that the disposal of pharmacy waste in bin bags in the undergrowth of a public park showed very poor judgement, a lack of professionalism, and a disregard for confidentiality in that some of the documents included staff details, as well as details of the Council's Inspector and case officer. Disposing of waste in this way also would have presented a burden on park users, volunteers and rangers.
113. The Registrant's conduct in particular 3 would, the Committee considered, also have posed a serious risk to the public. Recklessly dumping medication including prescription drugs and controlled drugs in plastic bags in a local park, undermined the very safeguards designed to protect patients and the public; anyone could have found the drugs and used them or diverted them to be used by others.
114. 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).
115. However, given the proven facts of this case, the Committee was satisfied that the Registrant's conduct individually and collectively fell short of what would be proper in the circumstances. It was of the view that his conduct would be regarded as deplorable by fellow practitioners and would convey a degree of opprobrium to the ordinary citizen. His behaviour was, in the words of the recent case of Forz Khan v Bar Standards Board [2018] EWHC 2184 (Admin), "*seriously reprehensible*".

116. The Committee therefore determined that the Registrant's conduct was serious enough to amount to professional misconduct.

Impairment

117. The Committee went on to consider whether the Registrant's fitness to practise is currently impaired.

118. Rule 5(2) of the Rules provides:

"In relation to evidence about the conduct or behaviour of the registrant which might cast doubt on whether the requirements as to fitness to practise are met in relation to the registrant, the Committee must have regard to whether or not that conduct or behaviour –

- a) presents an actual or potential risk to patients or to the public;*
- b) has brought, or might bring, the profession of pharmacy into disrepute;*
- c) has breached one of the fundamental principles of the profession of pharmacy; or*
- d) shows that the integrity of the registrant can no longer be relied upon."*

119. Guidance on this issue was set out by Mr Justice Silber in Cohen v General Medical Council [2008] EWHC 581 (Admin) at paragraph 65:

"It must be highly relevant in determining if a [practitioner's] fitness to practise is impaired that first ... her conduct that led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated".

120. These principles are echoed in the Council's "Good decision making: Fitness to practise hearings and outcomes guidance (2024) at paragraph 2.15:

“The committee should also consider whether:

- the conduct which led to the complaint is able to be addressed*
- the conduct which led to the complaint has been addressed*
- the conduct which led to the complaint is likely to be repeated*
- a finding of impairment is needed to declare and uphold proper standards of behaviour and/or maintain public confidence in the profession”.*

121. The Committee took into account the information before it relevant to the question of current impairment. This included the evidence of previous regulatory findings connected with the Registrant’s long-standing history of alcohol dependency. Most recently on 23 June 2026 the Registrant had emailed Mr Thomas stating that all of his conduct as alleged by the Council was due to (REDACTED.)
122. The Committee noted that this was a case based on the ground of misconduct, but the evidence before it was that the misconduct could have followed on from (REDACTED).
123. Turning to consider whether the Registrant’s fitness to practise is currently impaired as at today’s date, the Committee observed that the Registrant had not attended this hearing, and he had provided no submissions nor any information on the basis of which it could have assessed the Registrant’s insight or reflections upon his failings, or whether he has in any respect remediated his conduct.
124. It took into account the comments the Registrant made at the interim order hearing in May 2025 which Mr Thomas had drawn to its attention, which, it considered did demonstrate a degree of insight about the current concerns.
125. The Registrant had told the Committee then that the concerns alleged were due to (REDACTED.) The Determination continued:

“He expressed that he was disappointed with himself, but stated that he was now sober....When the Committee asked questions about any risk he represented to patients safety

he stated that he was (REDACTED.)

126. The Registrant had provided no evidence to this Committee however, (REDACTED). The Committee could not therefore find that the Registrant's conduct has as at the date of this hearing, been addressed.
127. As for whether the conduct is likely to be repeated, the Committee observed that whether or not the Registrant's misconduct took place against (REDACTED), this was nevertheless a Registrant in a responsible position as RP, with a previous very similar regulatory finding against him amounting to misconduct due to attending work whilst unfit to do so. This was not the first time therefore that the Registrant had behaved as has been found by this Committee. The Committee agreed with Mr Thomas that given the Registrant's previous very similar adverse regulatory finding the risk of repetition is higher than it might otherwise have been.
128. In these circumstances, the Committee has concluded that, on the basis of the evidence before it, the Registrant's conduct is likely to be repeated.
129. The Committee next turned to consider its findings in light of Rule 5(2) of the Rules. It accepted Mr Thomas's submissions that three limbs of Rule (5)(2), namely, (a), (b) and (c) are engaged by the Registrant's conduct.

Rule 5(2)(a)

130. The Registrant's conduct demonstrates behaviour that presents both an actual and potential risk to the public. Attending work whilst unfit to do so, having drunk alcohol, and especially in the senior role of RP on the day, clearly challenged the Registrant's ability to act responsibly and safely in a professional context. It presented a risk that he might make errors of judgement or simply abdicate responsibility (the Committee noted that the Pharmacy Incident Report recorded that the Registrant went to "rest in the office for a while" because

(REDACTED)). Given the Committee's finding that the risk of repetition is high, there remains a potential risk in future.

Rule 5(2)(b)

131. Pharmacy professionals are expected to attend work only when fit to do so and to dispose of potentially dangerous medications safely in accordance with regulatory guidance. The Registrant's conduct clearly was incompatible with that. His misconduct had the potential to diminish public trust and confidence in the profession and brought the entire profession of pharmacy into disrepute.

Rule 5(2)(c)

132. Fundamental principles of the profession of pharmacy include attending work only when fit to do so – because there are obvious risks to patient and public safety if they attend work unfit – and also disposing of medication safely and securely. The Registrant breached both those principles by his misconduct.

Rule 5(2)(d)

133. The Committee carefully considered whether the Registrant's integrity can no longer be relied on. As Mr Thomas had submitted, although it might be said that the Registrant's actions fell far below what a pharmacist acting with integrity would have done, this was a case in which it should question carefully whether or not the character of the misconduct, given the backdrop in relation to (REDACTED) is akin to a lack of integrity.
134. The Committee took into account that the Registrant had a previous regulatory finding against him for misconduct in attending work whilst unfit to do so, coupled with a finding of (REDACTED.) He had not been open and honest with colleagues and the staff of the nearby GP surgery on 27 September 2024 when he denied that he had been using alcohol on that day.

135. It also noted that the Committee at the Principal Hearing set out that he was given a Warning by the Council's Investigation Committee in 2012 for two occasions on which he did not notify the Council of convictions for drink driving offences which he received in 2005 and 2008.
136. (REDACTED)
137. On the other hand, the Registrant had admitted (after a few weeks) that he was responsible for the disposal of the medication and confidential waste in the park when asked about it by the Council's case officer; and he had admitted both in the IOR hearing and in an email to a Council case officer in May 2025, and very recently in his email to Mr Thomas, that his conduct then alleged was due to a (REDACTED.) Whilst he had not made formal admissions to the particulars, he appeared to have accepted that, for the most part, he had behaved as alleged.
138. Although the facts found proved are very serious, and the Registrant very clearly knew better, having gone through a previous regulatory process for similar conduct, and having received a regulatory Warning prior to that, there is compelling evidence before it that the Registrant's misconduct occurred (REDACTED)
139. In these circumstances the Committee has concluded that Rule 5(2) (d) is not currently engaged.
140. Turning lastly to consider the public interest, the Committee bore in mind the well-known case of CHRE v NMC and Grant [EWHC] 927 (Admin), in which Mrs Justice Cox stated that a panel must consider whether *"the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances"* of a case.
141. The Committee was satisfied that this case is clearly one, given its facts, in which there is a need to make a finding of current impairment in order to declare and uphold proper standards of behaviour and maintain public confidence in the profession.
142. For all the reasons set out above, the Committee finds the Registrant's fitness to practise is

currently impaired on grounds of public protection and otherwise in the public interest, that is, in order to promote and maintain public confidence in the professions regulated by the Council; and to promote and maintain proper professional standards and conduct for members of those professions.

Decision on Outcome

143. Having found impairment, the Committee went on to consider the appropriate outcome.

144. The Committee's powers in relation to sanction are set out in Article 54(2) of the Pharmacy Order 2010.

145. Article 54(2) of the Order provides:

"If the Fitness to Practise Committee determines that the person concerned's fitness to practise is impaired, it may–

- a. give a warning to the person concerned in connection with any matter arising out of or related to the allegation and give a direction that details of the warning must be recorded in the person concerned's entry in the register,*
- b. give advice to any other person or other body involved in the investigation of the allegation on any issue arising out of or related to the allegation;*
- c. give a direction that the person concerned be removed from the register;*
- d. give a direction that the entry in the Register of the person concerned be suspended, for such period not exceeding 12 months as may be specified in the directions; or*
- e. give a direction that the entry in the Register person of the person concerned be conditional upon that person complying, during such period not exceeding 3 years as may be specified in the direction, with such requirements specified in the direction as the Committee thinks fit to impose for the protection of the public or otherwise in the public interest or in the interest of the person concerned."*

The Committee may also make no order.

146. The Committee was aware that it should consider the available outcomes in ascending order from the least restrictive, taking no action, to the most restrictive, removal from the register, in order to identify the appropriate and proportionate outcome that meets the circumstances of this case. It bore in mind that the purpose of the outcome is not to be punitive, though an outcome may in fact have a punitive effect. The purpose of the outcome is to meet the overarching objectives of regulation, namely the protection of the public, the maintenance of public confidence and to promote and uphold professional standards. The Committee is therefore entitled to give greater weight to the public interest over the Registrant's interests.
147. The Committee had regard to the GPhC's guidance, entitled: Good decision making: Fitness to practise hearings and outcomes guidance (March 2024), ("the Good decision making Guidance") which reminds the Committee that it must consider the full range of outcomes.

Submissions on behalf of the Council

148. Mr Thomas provided the Committee with documentation relating to the Warning imposed on the Registrant by the Council's Investigating Committee in 2012. He submitted that this dates from events which took place nearly 20 years ago and the Committee should not take it into account in deciding on outcome but could bear it in mind when considering the background context regarding the Registrant's (REDACTED)
149. He proposed a number of aggravating and mitigating factors which the Committee should take into account and also referred to the fact that the Registrant has been suspended from practicing for about 19 months and this might also be relevant when the Committee considers proportionality of any potential outcome. He submitted that though this is not a health case and therefore it is open to the Committee to impose an outcome of removal, the Council's submission was that a period of 8-10 months with a review might be the appropriate outcome in this case.

The Committee's Decision

150. The Committee had regard to the relevant law and to the Council's 'Good decision making: Fitness to practise hearings and outcomes guidance' (March 2024)' ("the Good decision making Guidance"), to inform its decision. It took into account the submissions made by Mr Thomas and all of the relevant documentation.
151. The Committee first considered what, if any, aggravating and mitigating factors there may be.
152. The Committee identified the following aggravating factors:
- The Registrant has a regulatory history including an IC Warning dating from 2012 for not having informed the Council of two separate convictions for drink driving offences; and findings at a Principal Hearing in 2019 relating to attending work whilst unfit to do so and an (REDACTED);
 - Given the above, the Registrant would have known about the regulatory consequences of his conduct;
 - Whilst there was no evidence of patient or public harm, the Registrant's conduct in relation to the facts proved both individually and together could have caused serious harm to patients and the public;
153. The Committee identified the following mitigating factors:
- The misconduct is said by the Registrant to have (REDACTED)
 - No evidence of actual harm to patients or the public;
 - No confidential patient details were found discarded in the park;
 - The Registrant accepted that he should leave the Pharmacy when asked to do so by Dr M;

- The Registrant admitted that he had discarded the waste in the park; and admitted that he (REDACTED).
154. The Committee next turned to consider the sanctions or outcomes available to it in ascending order.
155. Take no Action: The Committee first considered where it would be appropriate to take no action, however it was of the view that this outcome would not protect the public nor would it be sufficient to reflect the seriousness of the Registrant's misconduct.
156. Warning: The Committee next considered whether issuing a Warning would be appropriate but it decided that a Warning would not be appropriate for the same reasons as above, namely that a Warning would not protect the public nor sufficiently mark the public interest, because, in the Committee's view, a Warning would not be proportionate to the seriousness of the Registrant's failings.
157. Conditions of Practice. The Committee next considered whether to impose conditions of practice. The Good decision making guidance states that conditions may be appropriate where there is evidence of poor performance, or significant shortcomings in a professional's practice, but the Committee is satisfied that the professional may respond positively to retraining and supervision; and where there is not a significant risk posed to the public by the imposition of conditions.
158. However this was not a case in which the Registrant's standard of professional practice was called into question – moreover, though the misconduct may be said to have taken place during the course of the Registrant's practice, and his past regulatory history demonstrates that he has in the past complied with conditions including undergoing substance use tests, he has not engaged with this regulatory matter in any meaningful way since June 2025. The Committee cannot therefore be assured that he would abide by any conditions it might consider appropriate to deal with the misconduct it has found proved.

159. In any event, the Committee is of the view an order for conditions would not be sufficient to mark the seriousness of the matter and send a clear message to the Registrant's professional colleagues and to the public that his conduct was unacceptable for a registered professional, so as to maintain public confidence in the profession and the regulator.
160. Suspension Order. The Committee next considered whether suspension would be a proportionate sanction.
161. It took into account that Mr Thomas had submitted, on behalf of the Council, that suspension would be an appropriate and proportionate outcome in this case, given the evidence that the Registrant's misconduct may have occurred against the backdrop of (REDACTED.)
162. The Committee carefully considered the Council's Good decision making guidance which indicates that suspension may be appropriate where:
"The Committee considers that a warning or conditions are not sufficient to deal with any risk to patient safety or to protect the public, or would undermine public confidence. When it is necessary to highlight to the profession and the public that the conduct of the professional is unacceptable and unbecoming a member of the pharmacy profession. Also when public confidence in the profession demands no lesser outcome".
163. The Committee took into account that the Council's Good decision making guidance states at paragraph 5.7 and 5.8 that in reaching a decision on what outcome to impose, the Committee should give appropriate weight to the wider public interest. The Committee is entitled to give greater weight to the public interest, than to the consequences for the professional. Even if an outcome will have a punitive effect, it may still be appropriate.

164. The Committee is satisfied that patients and members of the public would be appropriately protected during the period of any suspension of the Registrant's name from the register. It was also of the view that a period of suspension might assist the Registrant to gather evidence of (REDACTED) and provide appropriate material demonstrating insight and remediation for his misconduct which he might present to a committee at a review.
165. It therefore turned to consider whether a suspension would be adequate and proportionate to maintain public confidence in the profession and proper standards of behaviour.
166. In deciding on the appropriate and proportionate outcome, the Committee bore in mind that this case had been brought by the Council on the ground of misconduct, (REDACTED). However, the Committee took full account of the evidence which the Council had fairly brought to the Committee's attention, which suggested that the Registrant may have been (REDACTED.)
167. (REDACTED)
168. The Committee noted however that there appeared to have been only a relatively short period between the date he was returned to the register unrestricted (Principal Hearing Review in March 2023), and the (REDACTED.) The Registrant had provided no independent information to this Committee which might support what he had told the Interim Order Review committee in May 2025 to the effect that he was, then, "sober". This Committee has no evidence from the Registrant about (REDACTED.)
169. Taking all the above into account, the Committee has, after careful consideration, concluded that it is fair to impose a period of suspension on the Registrant's right to practise, together with a review before its end, in the hope that he can use this period to (REDACTED), and gather together the evidence which a reviewing committee will need to see in order to assess his fitness to practise at the date of any such review.

170. It is of the view that a suspension with a review will satisfactorily mark the seriousness and nature of its findings, and that members of the public, were they to be appraised of all the evidence in this case, would consider such an outcome to be appropriate, reasonable and fair.
171. The Committee concluded that the suspension should be for the longest period available, that is, 12 months, which will be proportionate to the seriousness of the concerns, and also may give the Registrant sufficient time to prepare for the review.
172. The Committee wishes to emphasise that as this is a case where serious misconduct has been found, removal from the register remains an option for the committee at the review. Given the Registrant's previous regulatory history, that may be an appropriate outcome at the first review if he is not able to demonstrate full, or at least significant steps towards, appropriate insight and remediation in relation to the serious failings found proved by this Committee.
173. The Committee hereby revokes the Interim Order of Suspension in this matter.
174. As stated above, the Committee considers that this is a case in which a review will be necessary before the expiry of the suspension. The reviewing committee would be assisted by the Registrant providing the following:
- i) The Registrant's attendance at any review;
 - ii) A reflective document demonstrating the Registrant's full insight into the seriousness of his misconduct, explaining that he understands what he should have done at the time and what he would do in future to avoid repeating his failings. He should set out his insight into and understanding of the risk to public protection and to the wider public interest;

- iii) Any testimonials he can provide about any work he has undertaken whether paid or voluntary;
- iv) (REDACTED)
- v) (REDACTED)
- vi) (REDACTED)

175. Removal. Having concluded that a period of suspension would satisfactorily deal with the issues of public protection and public interest which it has identified, the Committee considered whether removal was in fact more appropriate. The Committee took into account that removal is reserved for the most serious conduct. The Good decision making Guidance states that:

“Removing a professional’s registration is reserved for the most serious conduct... The committee should consider this outcome when the professional’s behaviour is fundamentally incompatible with being a registered professional”.

176. Taking all of the evidence into account, the Committee has come to the view that the Registrant’s conduct is not fundamentally incompatible with being a registered professional and therefore removal of his name from the register would be disproportionate.

177. The Committee therefore directs that the entry in the Register of Mr Jitendra Desai whose registration number is 2048785, be suspended from the register for a period of 12 months.

Decision on Interim Measure

178. Mr Thomas made an application for an interim measure of suspension to be imposed on the Registrant's registration, pursuant to Article 60 of the Pharmacy Order 2010, pending the coming into force of the Committee's substantive order. He submitted that such an order was necessary to protect the public and was otherwise in the public interest.
179. The Committee carefully considered the Council's application. It took account of the fact that its decision to order the suspension of the Registrant's name from the register will not take effect until 28 days after the Registrant is formally notified of the outcome, or until any appeal is concluded. The Committee also took into account the Council's Good Decision-making: Hearings and Outcomes Guidance of 2024.
180. The Committee has found that the Registrant's conduct merits an order of suspension because it considers there is a high risk of repetition and an order of suspension is therefore necessary for public protection and is also in the public interest.
181. The Committee is satisfied that it is therefore necessary for an interim measure of suspension to be in place from today's date, both because it is necessary to protect the public from potential harm should the Registrant repeat his conduct, and also otherwise in the public interest, to uphold proper professional standards and maintain confidence in the profession and the Regulator.
182. The Committee therefore hereby orders that the entry of the Registrant in the register be suspended forthwith, both on grounds of public protection and in the public interest, pending the coming into force of the substantive order.