General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote video-link hearing

29 June-3 July, 13-21 July, 22-24 July, 29-31 July 2026

Registrant name:	Mr Shyam Morjaria
Registration number:	2081035
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Martin Winter (Chair) Esosa Osakue (Registrant member) David Hutton (Lay member)
Legal Adviser:	Rebecca Thomas
Committee Secretary:	Ivana Raimundova (29 June-3 July, 22-24 July, 29-31 July) Gemma Staplehurst (13-21 July)
Registrant:	Not present and not represented
General Pharmaceutical Council:	Represented by Tom Hoskins, Case Presenter
Facts proved:	1, 2, 3, 4, 5, 6, 7, 8, 11, 13, 14, 15, 19 & 21 in its entirety, 10.1- 10.3, 10.5, 12.1-12.5, 16.2-16.8, 17.2-17.8, 18.3-18.9, 20.2-20.8
Facts not proved:	9, 10.4, 12.6, 16.1, 17.1, 18.1, 18.2, 20.1, 22, 23, 24
Fitness to practise:	Impaired

Outcome:	Removal
Interim measures:	Interim suspension Order

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 **2 September 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

1. Between 11 October 2018 and 6 September 2021, worked as the Superintendent Pharmacist ("SI") of UK Meds Direct Limited ("UK Meds").

2. You worked:

2.1 between 24 September 2018 and 4 September 2021as a Responsible Pharmacist ("RP") for UK Meds; and

2.2 between 4 December 2018 and 4 April 2019, as the regular RP for UK meds.

3. Between 4 May 2020 and 13 October 2021, you were a director of UK Meds.

4. In relation to paragraphs 1 and/or 2 above:

4.1. in your capacity as RP, you oversaw the dispensing of approximately 44,236 prescriptions including those for controlled and/or non-controlled high-risk medicines and/or medicines requiring ongoing monitoring; and/or

4.2. in your capacity as SI, you oversaw the prescribing of approximately 493,119 prescriptions including those for controlled and/or non-controlled high-risk medicines and/or medicines requiring ongoing monitoring.

5. In relation to paragraph 1 above, you failed to ensure and/or assure yourself that UK Meds and/or its Prescribers were prescribing in accordance with the guidance from the General Medical Council ("GMC"), the Royal Pharmaceutical Society ("RPS") and/or the General Pharmaceutical Council ("GPhC"), in that medicines were routinely prescribed in circumstances where Prescribers had:

5.1. failed to obtain adequate information in relation to the patients' health in advance of prescribing to ensure the supply was appropriate for the patient;

5.2. relied principally on the information received in an online questionnaire;

5.3. 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;

5.4. failed to request a face-to-face or virtual consultation with patients;

5.5. failed to adequately consider the possibility of medication dependence and/or misuse;

5.6. failed to share information about supplies of medicines with other relevant healthcare professional and/or refer patients back to their GP for appropriate assessment and/or review and/or monitoring; and/or

5.7. failed to put adequate safety-netting in place.

6. In relation to paragraph 2 above, you dispensed and/or oversaw the dispensing of prescriptions in circumstances where UK Meds prescribing model or service was incapable of supporting safe prescribing decision in that:

6.1. adequate identity checks were not in place;

6.2. no face-to-face or other virtual consultation took place;

6.3. patients provided information primarily through an online questionnaire;

6.4. between approximately, March 2019 and October 2019, the questionnaire at paragraph 6.3 above could be easily manipulated by patients as it highlighted to them answers which could prevent the supply of the medicine and permitted them to change their answers;

6.5. the system did not allow a Prescriber to see if and/or how a patient had changed their answers in the questionnaire pursuant to paragraph 6.4 above and/or;

6.6. patients who had been prescribed the same medicine before through UK Meds were not required to complete another questionnaire for repeat orders.

7. In relation to paragraph 4.2, you dispensed and/or oversaw the prescribing of all or some of the medicines in Schedule A to patients on the basis of a patient completed online questionnaire, when they are unsuitable to be prescribed on that basis.

8. In relation to paragraph 4.2 above, you oversaw a prescribing system where prescribers knew or should have known that some patients had made one or more previous orders from UK Meds for the same medicines requiring ongoing monitoring and/or medicines which were unsuitable to be prescribed on the basis of a patient completed online questionnaire.

9. In relation to paragraph 1 above, by the time of the GPhC's visit on 14 May 2019, you failed to ensure that Prescribers made adequate records of their justification for prescribing.

10. In relation to paragraph 1 above, by the time of the inspection on 3 September 2019, you failed:

10.1. to ensure that UK Meds had carried out audits to review the safety and quality of the services it provided;

10.2. to ensure that risk assessments were completed by UK Meds;

10.3. to ensure that Prescribers and/or Pharmacists were complying with UK Meds' Standard Operating Procedures ("SOPs") and/or policies;

10.4. to ensure that Prescribers were competent to prescribe in the areas covered by the prescribing service; and/or

10.5. to ensure that Prescribers made adequate clear records of their justification for prescribing in circumstances where a patient did not have a GP or did not consent to share information with their GP.

11. In relation to paragraph 1 above, by the time of the GPhC's visit on 1 November 2019, you failed:

11.1. to ensure that UK Meds had carried out audits to review the safety and quality of the services it provided;

11.2. to ensure that UK Meds' risk assessments addressed the risks associated with its model;

11.3. to ensure that UK Meds Prescribers and/or Pharmacists were complying with UK Meds' SOPs, policies and/or risk assessments;

11.4. to ensure that Prescribers make adequate clear records of their prescribing decisions;

11.5. to ensure that additional information requested by Prescribers was received prior to issuing a prescription; and/or

11.6. to ensure that before issuing a prescription that patients' GPs were given sufficient opportunity to confirm the appropriateness of the proposed supply and/or that monitoring was in place.

12. In relation to paragraph 1 above, by the time of the inspection on 7 October 2020, you failed:

12.1. to ensure that UK Meds implemented SOPs and/or policies to review the quality of the services it provided;

12.2. to ensure that UK Meds prescribing policies addressed the risks of the medicines it supplied;

12.3. to ensure that UK Meds had carried out risk assessments for medicines it supplied;

12.4. to ensure that UK Meds' prescribing service considered all the risks when patients did not provide authority and/or consent to contact their regular Prescriber/ GP;

12.5. to ensure Prescribers made adequate clear records of their prescribing decisions; and/or

12.6. to ensure that Clinical Leads regularly reviewed Prescribers' decisions.

13. In relation to paragraph 1, you failed to implement changes to improve the safety of UK Meds' operating systems and processes as set out in the Improvement Notices dated 27 September 2019 and 30 November 2020.

14. In relation to paragraph 1 above, you failed to identify that Prescribers were prescribing medicines liable to misuse and/or abuse to vulnerable patients, including to:

14.1. Patient 1;

14.2. Patient 3; and/or

14.3 Patient 13.

15. In relation to paragraph 1 above, between approximately 11 October 2018 and 26 October 2019, you oversaw the prescribing in circumstances where, on 97,599 occasions, the time taken by the Prescriber to consider the prescription would not have been sufficient for

the Prescriber to clinically evaluate the suitability of the high risk medication and/or medication requiring ongoing monitoring for the patient including:

15.1. read, consider, and assimilate the patient completed online questionnaire; 15.2. consider if it was clinically necessary to check with the patients' GP and/or contact their GP;

15.3. consider if it was clinically necessary to contact the patient and/or conduct a face-to-face or virtual consultation with the patient; and/or

15.4. consider if it was necessary to check the clinical background of the patient.

16. In relation to paragraph 2.1 above, on 12 September 2019, you dispensed and/or oversaw the dispensing of 100 tablets of codeine 30mg to Patient 2, a patient with a history of poor mental health and/or opioid dependence, in circumstances where you had not assured yourself that it had been prescribed in accordance with the relevant guidance from the GMC, RPS and GPhC, in that it was prescribed in circumstances where the Prescriber had:

16.1. failed to consider that the patient had already made one or more previous orders from UK Meds;

16.2. failed to obtain adequate information in relation to the patient's health in advance of prescribing;

16.3. relied principally on the information received in a patient completed online questionnaire;

16.4. failed to access and/or attempt to access the patient's 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/misuse history;

16.5. failed to request a face-to-face or virtual consultation with the patient; 16.6. failed to adequately consider the possibility of medication dependence and/or misuse;

16.7. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring; and/or

16.8. failed to put adequate safety-netting in place.

17. In relation to paragraph 2.2 above, on 19 December 2018 and 11 March 2019, you dispensed and/or oversaw the dispensing of modafinil, dihydrocodeine and pregabalin to Patient 4, a patient with a history of poor mental health, overdose and/or self-harm, in circumstances where you had not assured yourself that it had been prescribed in accordance with the relevant guidance from the GMC, RPS and GPhC, in that it was prescribed in circumstances where the Prescriber had:

17.1. failed to consider that the patient had already made one or more previous orders from UK Meds;

17.2. failed to obtain adequate information in relation to the patient's health in advance of prescribing;

17.3. relied principally on the information received in a patient completed online questionnaire;

17.4. failed to access and/or attempt to access the patient's 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/misuse history;

17.5. failed to request a face-to-face or virtual consultation with the patient;

17.6. failed to adequately consider the possibility of medication dependence and/ or misuse;

17.7. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring; and/or

17.8. failed to put adequate safety-netting in place.

18. In relation to paragraph 2.2 above, on 17 December 2018, you dispensed and/or oversaw the dispensing of 84 tablets of ibuprofen 600mg to Patient 5, a patient with a history of poor mental health, overdose and/or self-harm, in circumstances where you had not assured yourself that it had been prescribed in accordance with the relevant guidance from the GMC, RPS and GPhC, in that it was prescribed in circumstances where the Prescriber had:

18.1. failed to verify the patients age;

18.2. failed to consider that the patient had already made one or more previous orders from UK Meds;

18.3. failed to obtain adequate information in relation to the patient's health in advance of prescribing;

18.4. relied principally on the information received in a patient completed online questionnaire;

18.5. failed to access and/or attempt to access the patient's 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/ misuse history;

18.6. failed to request a face-to-face or virtual consultation with the patient;

18.7. failed to adequately consider the possibility of medication dependence and/or misuse;

18.8. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring; and/or

18.9. failed to put adequate safety-netting in place.

19. In relation to paragraph 2.2 above, on 11 January 2019, 29 January 2019 and 18 March 2019, you dispensed and/or oversaw the dispensing of 100 tablets of dihydrocodeine 30mg to Patient 10, a patient with a history of poor mental health and/or opioid overuse, in circumstances where you had not assured yourself that it had been prescribed in accordance with the relevant guidance from the GMC, RPS and GPhC, in that it was prescribed in circumstances where the Prescriber had:

19.1. failed to consider that the patient had already made one or more previous orders from UK Meds;

19.2. failed to obtain adequate information in relation to the patient's health in advance of prescribing;

19.3. relied principally on the information received in a patient completed online questionnaire;

19.4. failed to access and/or attempt to access the patient's 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/misuse history;

19.5. failed to request a face-to-face or virtual consultation with the patient;

19.6. failed to adequately consider the possibility of medication dependence and/or misuse;

19.7. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring; and/or

19.8. failed to put adequate safety-netting in place.

20. In relation to paragraph 2.2 above, on 10 December 2018 , you dispensed and/or oversaw the dispensing of 100 tablets of dihydrocodeine 30mg to Patient 16, a patient with a history of poor mental health, overdose and/or self-harm, in circumstances where you had not assured yourself that it had been prescribed in accordance with the relevant guidance from the GMC, RPS and GPhC, in that it was prescribed in circumstances where the Prescriber had:

20.1. failed to consider that the patient had already made one or more previous orders from UK Meds;

20.2. failed to obtain adequate information in relation to the patient's health in advance of prescribing;

20.3. relied principally on the information received in a patient completed online questionnaire;

20.4. failed to access and/or attempt to access the patient's 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/ misuse history;

20.5. failed to request a face-to-face or virtual consultation with the patient;

20.6. failed to adequately consider the possibility of medication dependence and/or misuse;

20.7. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring; and/or

20.8. failed to put adequate safety-netting in place.

21. In relation to paragraph 4 your approach to prescribing and/or dispensing in any or all of paragraphs 5 to 20 above was transactional in that you and/or your staff processed patient

requests by reference to a patient completed online questionnaire rather than in accordance with UK prescribing guidance.

22. In relation to paragraphs 1 and/or 3 above, you entered into business agreements with third-party online pharmacies to dispense medicines in circumstances where the UK Meds' prescribing model or service was incapable of supporting safe prescribing decision(s) in that:

22.1. patients provided information primarily through an online questionnaire;

22.2. no face-to-face or other virtual consultation took place; and/or

22.3. UK Meds was not registered with an appropriate UK regulator.

23. Between June 2021 and 13 October 2021, UK Meds facilitated access and/or signposted patients to EU Meds Direct Limited ("EU Meds"), a prescribing service based in Dubai, in circumstances where EU Meds' prescribing model or service was incapable of supporting safe prescribing.

24. In relation to paragraphs 22 and/or 23 above, you oversaw deliberate attempts to circumvent the GPhC's conditions that prevented UK Meds' sale or supply of Schedule 1-5 Controlled Drugs, modafinil and amitriptyline, in that:

24.1. UK Meds' website provided a link signposting patients to EU Meds; and/or

24.2. EU Meds was outside a UK regulator's jurisdiction.

By reason of the matters above, your fitness to practice is impaired by reason of your misconduct.

Documentation

Document 1- Council's hearing bundle

Document 2- Council's skeleton argument

Document 3- Registrant's bundle

Document 4- UK Meds videos of website links

Document 5- UK Meds spreadsheets

Document 6- Proof of service bundle

Document 7- Proceeding in absence application bundle

Document 8- Email to the Registrant confirming proceeding in absence

Document 9- Interim order decision

Document 10- Schedule A

Document 11- Exhibit RC09

Document 12- Supplementary closing note

Document 13- 2nd Supplementary closing note

Document 14- Pt 5 checks and 2017 SOP

Document 15- Registrant's submissions on impairment

Document 16- GPhC's submissions on impairment

Witnesses (gave evidence at facts stage)

1. GC, Expert in the field of medical practice
2. AR, GPhC Customer Services Tam Operations Support Officer
3. SO, GPhC Senior Data Analyst and Insight Manager
4. MA, GPhC Professionals Regulations Manager
5. TM, Director of Digital Forensics for TKM Technologies Limited
6. RC, GPhC Inspector
7. JK, Consultant in Critical Care Medicine and Anaesthetics
8. AP, GPhC Inspection Operations Manager
9. NR, GPhC Senior Clinical Advisor and Specialist Instructor

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. Sanction – the Committee considers what, if any, sanction should be applied if the Registrant's fitness to practise is found to be impaired.

Service of Notice of Hearing

6. The Committee has seen a letter dated 26 May 2026 from the Council headed 'Notice of Hearing' addressed to the Registrant and sent to their registered email address and postal address as noted on the Register.

7. The Committee was satisfied that there had been good service of the Notice of Hearing ('Notice') in accordance with Rules 3 and 16 of the Rules.

Application to proceed in the absence of the Registrant

8. The Registrant was not in attendance at this hearing, nor was someone attending on their behalf. The Committee heard submissions from Mr Hoskins, on behalf of the Council to proceed in the absence of the Registrant under Rule 25.

9. The Committee noted that the Registrant was sent the Notice of Hearing via email on 26 May 2026 and that this was also sent special delivery to the Registrant's address as it appears on the Register on the same date. There was evidence that this was delivered and signed for by someone with the surname 'Morjaria' on 28 May 2026. Service has therefore been properly effected.

10. The Committee further noted correspondence received from the Registrant on 29 May 2026 by email which stated *"…I confirm that I do not intend to attend the hearing and I do not intend to call any witnesses".* The Committee's panel secretary emailed the Registrant back on the same day to acknowledge this decision and warned him that whilst this is "*entirely your choice…I would encourage you to consider the implications of not being present. In particular, you won't be able to address the committee directly, respond to any questions they may have or challenge the evidence given by the Council's witnesses. If you change your mind at any point, and decide that you would like to attend, please let me know so that the arrangements can be made".* There was no response to this by the Registrant.

11. The Committee accepted the advice of the Legal Adviser in respect of Rules 25, 16 and 3 of the General Pharmaceutical Council (Fitness to Practice and Disqualification Rules) Order of Council 2010 ("the Rules"), the guidance in *GMC v. Adeogba* [2016] EWCA Civ 162 and the necessity for it to exercise its power to proceed in the Registrant's absence with the utmost care and caution.

12. The Committee decided to proceed in the absence of the Registrant for the following reasons:

- The Committee has found good service of the Notice and has taken into account the email correspondence from the Registrant on 29 May 2026 which indicated his intention not to attend. The Committee is therefore satisfied the Registrant is, or should be, aware of today's proceedings and that he has waived his right to attend today and has chosen to voluntarily absent himself from this hearing.
- The Registrant has not requested an adjournment of these proceedings and there was no information to suggest an adjournment would result in the Registrant's attendance in future in any event.
- The Committee accepts that proceeding in the absence of the Registrant would cause some disadvantage to the Registrant and has considered this matter very carefully but recognises that there is a public interest in the expeditious disposal of cases and the Registrant has made it clear that he has chosen to voluntarily absent himself from these proceedings.
- Not proceeding would inconvenience witnesses who are ready to give evidence and detrimentally affect the expeditious resolution of this case which is now quite old. The Committee therefore considers it to be in the public interest to proceed in the Registrant's absence today.

Application to amend the particulars of allegation

13. The Committee heard an application at the outset from Mr Hoskins, under Rule 41 to amend particulars 7, 15 and 23 as follows:

1. *In allegation 7, there is currently reference to paragraph 4.1, which incorporates the Registrant's role as RP with a focus on 'dispensing'. The Council state this is at odds with the evidence in Schedule A which provides the figures for the times in excess of those when the Registrant was acting as RP. The Council applied to*

*amend reference to paragraph 4.1 to paragraph **4.2** (thereby reflecting the Registrant's role as SI) and to amend the reference to dispensing with "**oversaw the prescribing".***

2. *In allegation 15, the period stated as being between "11 October 2018 and 26 September 2019" is an error and the latter date should read "26 **October** 2019". There was also an application to amend the phrase "most" in "on most occasions, the time taken by the Prescriber to consider the prescription…" to the precise figures referenced from the evidence of TM so that it reads "on **97,599** occasions, the time taken by the Prescriber to consider the prescription would not have been sufficient to clinically evaluate the suitability of **the high risk medication and/or medication requiring ongoing monitoring** for the patient including…"*

3. *In allegation 23, there is a date missing where it reads "between June 2021 and 2021". The application is to insert "23 October" here so that it reads "between June 2021 and **23 October** 2021".*

14. Mr Hoskins submitted that the amendments were necessary to correct errors which were at odds with the evidence presented and should reflect how that evidence had always read. He submitted that use of the word 'most' in allegation 15 was imprecise and in fairness to the Registrant should be clarified so that he knew precisely what he was alleged to have done. Furthermore, the existing evidence of the witness, TM, had the relevant total figures within it which were preferable. Mr Hoskins submitted that no prejudice would be caused because the underlying evidence has remained the same and has been in existence for over a year and that the amendments provided greater clarify to assist the parties and the Committee in quantifying the allegation of misconduct rather than broadening or expanding them.

15. The Committee accepted the advice of the Legal Adviser who drew the Committee's attention to Rule 41 and the need to consider whether any amendment would prejudice the fairness of the proceedings.

16. The Committee was satisfied that allowing the amendments was in the interests of justice. It took the view that doing so would not prejudice the fairness of the proceedings against the Registrant. This was because the amendments would ensure clarity and accuracy to the allegations, corrected typographical errors and better reflected the evidence already before the panel. The amendments did not change the fundamental nature of the charges against the Registrant or introduce new allegations against him. The amendments would therefore assist in the fair and just disposal of the case.

Further application to amend particulars

17. On 14 July 2026, the panel heard a further application to amend the charges under Rule 41 in respect of particulars 4.1 and 4.2 in that the figures contained within were the result of an error in the calculations made by the Council.

The particulars currently read as follows:

"4. In relation to paragraphs 1 and/or 2 above:

4.1. in your capacity as RP, you oversaw the dispensing of approximately 44,236 prescriptions including those for controlled and/or non-controlled high-risk medicines and/or medicines requiring ongoing monitoring; and/or

4.2. in your capacity as SI, you oversaw the prescribing of approximately 493,119 prescriptions including those for controlled and/or non-controlled high-risk medicines and/or medicines requiring ongoing monitoring."

18. Mr Hoskins submitted that the figures in these charges should read as 43,186 and 378,885 respectively. He referred the panel to page 2145 of the bundle which was TM's witness statement. Mr Hoskins submitted that the entries shown in the second and third columns on this page are already included in the numbers shown in the first column, but when the Council charged this, they had evidently not realised and charged a higher number of prescriptions by mistake. Mr Hoskins submitted that it

was necessary and appropriate to amend the charges to reflect the correct figures as otherwise there was a risk of double-counting. He submitted that amending the charge would be to the Registrant's benefit as it made the charges less serious and did not otherwise change the nature of them.

19. The panel took advice from the legal assessor.

20. In doing so, it reminded itself that it could amend an allegation at any stage before making its findings of facts unless it was of the view that the amendment would prejudice the fairness of the proceedings.

21. Whilst the panel accepted that the Registrant was not present and that allowing an amendment meant that the Council was able to correct a charge that might otherwise have been found not proved, it considered the amendment to particular 4.1 was relatively minor, particularly in light of the current charge being an approximation of those figures. It also considered that both charges would benefit from the clarity and accuracy that the amendment would bring and that it actually made the charges less serious for the Registrant. It took into account the overall fairness of the proceedings and the duties of the Council under section 6 of the Pharmacy Order to protect, promote and maintain the health, safety and well-being of members of the public and in the circumstances did not consider that such an amendment would prejudice the fairness of proceedings.

22. It therefore granted the application to amend particulars 4.1 and 4.2.

Application to admit hearsay evidence

23. On 14 July 2026, the panel heard an application to admit hearsay evidence from the case presenter, Mr Hoskins, under Rule 24 in respect of the following categories of evidence:

- Witness statements of patient's relatives for other proceedings, namely: patient 5's father, patient 14's mother, patient 2's mother, patient 4's father and EC who recounts information provided by the parents of patient 13 which is multiple hearsay;
- Documents raising concerns about UK Meds;
- Statements providing medical evidence or opinions in respect of specific patients, including the report of LF for HM Coroner in respect of patient 4 and various GP reports;
- UK Meds' information from MS and answers to the Council's disclosure questions;
- Evidence provided to the GPhC by Pharmacist Independent Prescribers ('PIPs') at UK Meds against whom enforcement action was taken

24. Mr Hoskins submitted that the evidence contained within these five different categories was all relevant to the issues in the case and that it was fair to admit it. He went through each category and addressed the panel in respect of the seven principles set out in Thorneycroft v. NMC [2014] EWHC 1565 (Admin), namely:

(i) Whether the statements were the sole or decisive evidence in support of the charges;
(ii) The nature and extent of the challenge to the contents of the statements;
(iii) Whether there was any suggestion that the witnesses had reasons to fabricate their allegations;
(iv) The seriousness of the charge, taking into account the impact which adverse findings might have on the Registrant's career;
(v) Whether there was a good reason for the non-attendance of the witnesses;
(vi) Whether the Council had taken reasonable steps to secure their attendance; and
(vii) Whether the Registrant had prior notice that the witness statements were to be read.

25. The panel took advice from the legal assessor.

26. In considering this application, the panel gave careful consideration to not just the five categories of hearsay evidence, but the individual statements and documents referred to within these categories. It reminded itself that the admission of hearsay evidence should not be regarded as a routine matter and should be exercised with caution. It also considered the principles set out in Thorneycroft and looked at each item of evidence against these.

27. In respect of the witness statements, the panel considered that all of these statements, save for that of EC, were from relatives of patients who had been directly affected by the unsafe prescribing practices that occurred when the Registrant was either the SI or RP overseeing such practice. It noted that their evidence was not the sole or decisive evidence in respect of the charges against the Registrant; rather these statements gave important background and context to the charges. It noted that the Registrant had not directly challenged the contents of any of these statements including the police officer's; in fact, the Registrant had only made comments in Exhibit 6 about patients 4 and 5 but this appeared to be his reflections [and remorse] about their outcomes as opposed to any challenge to the evidence concerning them.

28. The panel did not consider there was any evidence to suggest these witnesses had reason to fabricate the allegations contained within their statements and it noted, for example, that EC was relaying information told to her in the course of her role as a police officer and that her statement was prepared for a coroner's inquest so fabrication seemed unlikely.

29. The panel considered for all of the hearsay evidence in all five categories that the charges were serious and gave due account to the impact these proceedings might have on the Registrant's career. In light of the seriousness of the charges, the panel carried out a careful balancing exercise in respect of considering the relevance and fairness of these hearsay statements.

30. In respect of whether there was a good reason for the non-attendance of these witnesses and whether the Council had taken reasonable steps to secure their attendance, the panel considered there was such good reason. These witnesses were all relatives of patients who had been affected by the unsafe prescribing practice carried out under the Registrant (and some concerned fatalities) and so the panel considered that having to give live evidence would likely have caused real distress to the witnesses. It noted, in particular that the Registrant had been sent the Notice of Hearing for these proceedings including the opening note and the witness statements back in February 2026 and yet had not raised any objection to their evidence being heard nor adduced as hearsay evidence nor has he indicated he had any particular questions for these witnesses. In light of this, the panel considered there was a good reason for their non-attendance and the Council's decision not to call them.

The panel therefore considers that these statements are both relevant to these proceedings and that it is fair to admit them into evidence.

31. In respect of the hearsay evidence that showed concerns being raised about UK Meds, the panel noted that this evidence largely seemed to concern referrals to the GPhC by other pharmacists and members of the public about UK Meds and its practices and anonymous trust pilot reviews.

32. The panel considered this to be relevant as it showed the first concerns raised with the GPhC and indeed the responses to those and this set the background to the charges. It was not the sole or decisive evidence against the Registrant nor does the evidence appear to have been challenged by him at any point. In that respect, the panel considered this to be a good reason why such witnesses had not been called to give evidence as there has been no indication that the Registrant would want to challenge their evidence. The Registrant was sent the bundle of evidence by the Council and Mr Hoskin's opening note two weeks before the hearing which indicated the Council's intention to apply to admit this evidence as hearsay – albeit the panel

has borne in mind that Mr Hoskins has elaborated on which pages of evidence he relies upon in his submissions today which the Registrant won't necessarily have had notice of - but he *was* put on notice of the general category of this evidence which would be the subject of a hearsay application and has not raised any objections or requested that any such witnesses attend.

33. The panel has also noted that there is no evidence that any of these witnesses raising concerns about UK Meds have fabricated their evidence, and indeed some of their concerns (about EU Meds for example) were independently tested and corroborated by AP and RC who sought to access the same website.

The panel therefore considers that the concerns about UK Meds are both relevant to these proceedings and that it is also fair to admit them into evidence.

34. The panel next considered the category of statements with medical evidence or opinions in respect of specific patients, including the report of LF for HM Coroner in respect of patient 4 and various GP reports. The panel considers this evidence to be reliable and relevant in much the same way as EC's evidence; namely that the medical reports and statements are from medical professionals doing their jobs therefore there is less likely to be a suggestion of fabrication or concerns about credibility. The panel noted that this evidence was not the sole or decisive evidence in support of these charges and that their content had not been challenged by the Registrant, despite him being notified not only of the application to admit this evidence as hearsay in Mr Hoskins' opening note but also by serving him with the evidence by way of the bundle prior to this hearing. It does not therefore appear to have been necessary for the Council to secure these witness' attendance.

The panel therefore considers that the medical evidence from GPs and reports prepared for the coroner's inquest are both relevant to these proceedings and that it is also fair to admit them into evidence.

35. The panel next considered the documentary evidence from MS and his answers to the Council's disclosure questions.

36. The panel thought carefully about this evidence because it is the sole and decisive evidence in respect of two of the charges (particulars 4 and 15). It also considered whether it was, in fact, even hearsay evidence at all, it largely appearing to contain raw data taken from internal computer databases. In any event, the panel considered it was likely to be evidence which were business records produced by way of a trade or profession and therefore less likely to be influenced or tainted by witnesses and therefore relevant and fair for the panel to consider.

37. The panel did consider whether Mr MS's position as a director of UK Meds which was itself under investigation by the GPhC at that time meant that he might have had a reason to fabricate such evidence or otherwise make it unreliable. But it noted there was no evidence of fabrication and that the witness statement signed by Mr MS contained a statement of truth and confirmed that he had produced his statement and schedules in his capacity as director of the company and that the board of directors (which included the Registrant at that time) had had sight of the statement and approved the filing and service of the statement and schedules. The panel is therefore satisfied that the Registrant had had sight of this evidence on more than one occasion and had not suggested Mr MS should attend or that the Registrant had any questions for him. It therefore considers it reasonable that the Council did not take steps to secure Mr MS's attendance in the circumstances.

The panel therefore considers that the evidence and disclosure from Mr MS is both relevant to these proceedings and that it is also fair to admit them into evidence.

38. The panel finally considered the evidence provided to the GPhC by PIPs at UK Meds against whom enforcement action was taken.

39. The panel noticed that this evidence appears to relate to documents provided to the GPhC by three anonymised PIPs (one being a complaint) about the practices at UK Meds. The complaint was made after one of the PIP's contract had been terminated by UK Meds and so the panel considered that their evidence, if admitted, should be treated with caution as it could be tainted by grievances against UK Meds and its directors. The panel considered the evidence to be relevant to the background and context of this case as these were documents provided by pharmacists working at UK Meds during the relevant time when the Registrant was SI and their concerns in respect of UK Meds' policies and practices which the Registrant would have had oversight of. The suggestion, amongst others, was that pharmacists were under scrutiny if they refused too many prescriptions.

40. Before it made its decision on this category of hearsay evidence, the panel asked for further information from the Council as to why these witnesses had been anonymised and why they had not been called as witnesses if they were professional pharmacists themselves. It was informed that they were each subject to Fitness to Practise proceedings themselves and that at least one had been approached to give a witness statement, but this had not been followed up. The panel had some concerns about this and considered the application to admit such evidence very carefully in light of this.

41. Overall, it considered that the evidence should, on balance be admitted because it was relevant to the charges giving useful background and context to the case and fair to admit it. This was because it was not the sole or decisive evidence against the Registrant, rather it provided background information that was relevant. In that respect, the panel could understand why the Council may not have felt it necessary to ensure these witnesses were in attendance. Additionally, it was noted that the Registrant had not raised any objection about this evidence going before the panel, having been notified that it was in the bundle when it was sent to him on 19 June 2016 nor had he raised any particular issues about this evidence in his submissions.

The panel therefore considers that the evidence from these three PIPs is both relevant to these proceedings and that it is also fair to admit it into evidence.

Further Application to Amend Charge

42. On 16 July 2026, the Committee heard a further application to amend particular 7 insofar as it related to Schedule A which contained a list of medications that the Registrant oversaw the dispensing of in his role as RP. In fact, the list of medications should have related to his role as SI whereby he oversaw the prescribing of certain medications. This alteration meant that the figures in the schedule needed to be amended because this was a different subset of Exhibit SO/01. Mr Hoskins submitted that the amendment was therefore required to reflect the true nature of the evidence as presented by the Council.

43. The panel noted that the change in figures required to reconcile particular 7 and Schedule A meant that that these figures changed quite significantly. However, it noted that in agreeing to the earlier amendment to particular 7 (to change it from particular 4.1 to 4.2 which reflected the Registrant's role as SI and not RP), the figures in Schedule A inevitably had to also change to reflect this. Whilst the figures were much higher in some categories, they did reflect the evidence as presented by the Council and therefore this amendment was more akin to a slip of the pen type error and did not change the nature of the charges the Registrant faced.

The panel therefore agreed to the amendment of particular 7 insofar as it concerned Schedule A.

Registrant's response to Particulars of allegation

44. The Registrant has not provided substantial response whether he admits or denies all the particulars against him, meaning that the Council are obligated to establish all the allegations to the requisite standard, that is the civil standard of proof.

45. The Committee went on to receive evidence and submissions regarding the particulars.

Background

46. The Registrant was registered as a pharmacist with the GPhC from 1 August 2012 after which he worked at various pharmacies in a variety of pharmaceutical roles until joining UK Meds as a Responsible Pharmacist ("RP") on 24 September 2018 and then as the Superintendent Pharmacist ("SI") from 11 October 2018.

47. The allegations relate to the Registrant's role as an SI and RP with oversight responsibilities during his time at UK Meds. Each allegation addresses a specific aspect of professional conduct and patient safety, reflecting concerns raised by regulatory inspections and prescribing data.

48. As SI, the Registrant was not a prescriber and so did not undertake prescribing functions himself but had a role which included governance, operational oversight and safeguarding. However, the GPhC allege that he was in a senior supervisory role which carried with it the responsibility of ensuring those who did prescribe did so safely and in accordance with GPhC guidance.

49. Prescribers did not have access to patient's medical records but could follow up with the patients to ask further questions either by email or telephone. The GPhC alleges that this happened rarely if ever and that there was little, if any, adequate communication with the patients' GPs before prescribing. During the period when the Registrant was SI, it is alleged there was informed consent from patients in only 8,136 occasions across almost half a million occasions of high-risk medication being

prescribed and that the prescribing model operated by UK Meds at this time was unsafe.

50. Specifically, there were concerns with regards to patients who were able to access medication easily when they were either too young to access the UK Meds website, or had a history of poor mental health that meant that they either misused or abused medication that was prescribed to them. Some had addictions to these medicines and some unfortunately used similar medication to self-harm.

51. UK Meds first registered with the GPhC on 15 August 2017 at an address in Nottingham and voluntarily removed itself from the GPhC's register on 11 March 2019. Just prior to this deregistration, on 1 March 2019 it obtained a second registration linked to a different address in Nottingham.

52. UK Meds was an online pharmacy operating 7 days a week. Its processes were as follows:

- Customers would access its website and fill in an online questionnaire.

- This questionnaire would be considered by a prescriber working remotely. Initially, the prescribers were a team of GMC registered doctors supplied through an EU based company but after June 2019 this role shifted to a team of Pharmacist Independent Prescribers ("PIPs") who were paid per prescription or per hour and supervised by the Clinical Lead ("CL").

- UK Meds expected the PIPs to make decisions autonomously and using their own clinical judgment in accordance with their individual regulatory responsibilities.

- Dispensing activities were overseen by the RP, who had access to the UK Meds' system to check which prescriptions had been previously dispensed in-house. At

this time, UK Meds' pharmacists were fulfilling approximately 15,000 orders a month encompassing a variety of medication including opiates, z-drugs, erectile disfunction treatment and modafinil. Customers would require identity checks via official software (such as Experian) during the consultation process.

- Where further follow-up was conducted with the patients this would be done over email or by phone, generally by the PIPs themselves or escalated to the CL.

- There was infrequent communication with a patient's GP either before or after the PIP's prescribing decision, even where the questionnaire indicated that consent had been given by the patient for their GP to be contacted.

- Following a prescription being issued by a PIP, it would be dispensed by the in-house pharmacy team from UK Meds or issued by a number of different third-party pharmacies that UK Meds contracted with and sent to the patient by post or courier.

53. In March 2019, UK Meds received a Statutory Improvement Notice due to concerns about vulnerable patients receiving inappropriate medicines. Required improvements included gathering full patient information, ensuring safe prescribing, safeguarding vulnerable clients, identifying misuse risks, and sharing prescription information with other healthcare professionals.

54. In April 2019, the GPhC updated its published guidance on pharmacies providing services at a distance.

55. By May 2019, UK Meds was issuing roughly 750 daily orders, and by June 2019 the minimum standards were said to have been met however
persistent issues were flagged in a follow-up visit by the GPhC. In September 2019, inspectors found systemic weaknesses such as inadequate risk assessments for high-risk medicines, over-reliance on patient questionnaires, minimal GP interaction, and

lack of routine consultations or patient advice. Despite internal staff concerns, no corrective action was taken. The GPhC inspectors identified that some improvements had been made but that there remained concerns particularly surrounding the gathering and sharing of relevant information with other healthcare professionals.

56. In September 2019, a further follow up inspection was conducted where concerns were identified including an absence of risk assessments when prescribing, particularly in relation to high-risk medicines liable to be abused or cause addiction and medicines which required ongoing review and management. The inspection reported that there was a reliance on questionnaire answers provided by the patient, which alerted the patient when their answer would prevent the prescription being issued and allow them to change their answer. There also remained inadequate contact with healthcare professionals and an absence of routine face to face consultations with patients. A second Statutory Improvement Notice was then issued requiring UK Meds to complete risk assessments for all services, make changes to the website (such as ensuring it does not alert the patient to which answers raise questions about clinical appropriateness), ensure GPs are contacted in advance of prescribing and relevant information shared. These improvements were to be in place by late October 2019.

57. In November 2019, a further follow-up visit did not satisfy the inspectors that the requirements of the improvement notice had been met save for the website had been amended to prevent patients being alerted about their answers. Shortly thereafter the GPhC imposed a Notice of Conditions on UK Meds prohibiting them from selling or supplying Schedule 1 to 5 controlled drugs and Modafinil. UK Meds applied to revoke these conditions in February and December 2020 but these applications were rejected.

58. In October 2020, during the COVID pandemic, a further GPhC inspection revealed ongoing deficiencies in managing online medicine supply risks. It reported continued issues, including a lack of an adequate clinical governance structure and continued failure to conduct face to face consultations with patients and an over reliance on

patient questionnaires. A further improvement notice was served in November 2020 which, despite further engagement from UK Meds during this time, it failed to comply with.

59. In March 2021, UK Meds was prohibited from supplying Amitriptyline due to concerns about continued supply of this drug based on the patient questionnaire with no input from the patients' GP and no access to medical records.

60. In July 2021, a final Notice of Conditions was issued to UK Meds preventing it from advertising and providing links to a website called EUmeds.com which was registered in the Middle East. The Notice alleged that UK Meds had consistently failed to meet the standards set under article 7(1) of the Pharmacy Order 2010 to ensure safe and effective pharmacy care.

61. On 6 September 2021, UK Meds again voluntarily removed itself from the register. The Registrant resigned from his role as SI the day before.

Decision on Facts

62. In reaching its decisions on facts, the Committee considered the documentation listed at the start of this determination, oral evidence and the submissions made by the Council and the Registrant in a bundle of documents referred to as Exhibit 6 running to 383 pages.

63. The Committee accepted the advice of the Legal Adviser.

64. The Committee has drawn no adverse inference from the non-attendance of Mr Morjaria.

65. 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.

66. The Committee heard live evidence from the following witnesses called on behalf of the GPhC:

- GC – Expert in the field of medical practice
- MA – Professionals Regulations Manager, GPhC
- AR - GPhC Customer Services Team Operations Support Officer
- SO – GPhC Senior Data Analyst and Insight Manager
- TM – Director of Digital Forensics for TKM Technologies Limited
- RC – GPhC Inspector
- JK – Consultant in Critical Care Medicine and Anaesthetics
- AP - GPhC Inspection Operations Manager
- NR – GPhC Senior Clinical Advisor and Specialist Inspector

67. Before making any findings of fact, the Committee heard and accepted the advice of the Legal Adviser.

68. The Committee then considered each of the charges and made the following findings:

Particular 1

Between 11 October 2018 and 6 September 2021, worked as the Superintendent Pharmacist ("SI") of UK Meds Direct Limited ("UK Meds").

69. The Committee took into account the witness statement of AR, Customer Services Team Operations Support Officer at the Council. She said that the Registrant first registered with the GPhC on 1 August 2012 and that on 11 October 2018 he was appointed as the SI for UK Meds. She produced a copy of the Nomination of a Superintendent Pharmacist form naming the Registrant as the SI as her exhibit AR/01. Ms AR further confirms that the Registrant ceased to be the SI of UK Meds on

6 September 2021. She has produced as her exhibit AR/02 a copy of the Notification of the resignation of a Superintendent Pharmacist form confirming this which the Committee can see was signed by the Registrant on 6 September 2021.

Particular 1 is found proved.

Particular 2

You worked:
2.1 between 24 September 2018 and 4 September 2021 as a Responsible Pharmacist ("RP") for UK Meds; and
2.2 between 4 December 2018 and 4 April 2019, as the regular RP for UK meds.

70. The Committee took into account the witness statement of MA, Professionals Regulation Manager at the GPhC, who produced as her exhibit MA/04 a copy of The Pharmacy Record held by UK Meds which appears to be a record of who was the RP on each date. The Committee has reviewed this evidence and can see that the Registrant was listed as the RP on the following dates:

- 24, 25 September 2018
- 17, 18, 22 October 2018
- 29 October 2018 to 2 November 2018
- 7, 9 November 2018
- 4, 5, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 27 December 2018
- 2, 3, 4, 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 29, 30, 31 January 2019
- 4, 5, 6, 7, 8, 11, 12, 15, 18, 21, 22, 26, 27, 28 February 2019
- 1, 2, 3, 4, 5, 6, 7, 8, 11, 12, 18, 19, 26, 27, 28, 29 March 2019
- 1, 2, 3, 4 April 2019
- 26 July 2019
- 2 August 2019
- 12, 13 September 2019

- 6, 7 February 2020
- 2 May 2020
- 16 July 2020
- 19 September 2020
- 23 November 2020
- 16 January 2021
- 13 February 2021
- 13 March 2021
- 1 May 2021
- 1 June 2021
- 17, 24, 26 July 2021
- 6, 21, 24 August 2021
- 4 September 2021

71. The Committee is aware that the Registrant's position is that he "*occasionally undertook Responsible Pharmacist duties and supported the dispensary where operational pressures required it".* He says that this was "*not my main role but it formed part of the wider reality of working in a growing business with a lean governance structure."*

72. The Committee noted that particular 2.1 does not suggest that the Registrant worked every day as the RP between 24 September 2018 and 4 September 2021 or that it was his main role, just that he did work as the RP between these dates. The Committee considers this is borne out by the evidence, namely the evidence from AP, Inspection Operations Manager at the GPhC who said that the Registrant worked occasionally as UK Meds' RP between September and November 2018 and that from December 2018 to the beginning of April 2019, he was the main, regular RP, and that after this date, the Registrant worked as the RP every one to two months until September 2021. Also, the dates shown on The Pharmacy Record with the Registrant's name and registration number recorded next to these show that between 24 September 2018 and 4 September 2021 he was indeed working in the

RP role. The Committee is therefore satisfied that between 24 September 2018 and 4 September 2021 the Registrant was working in this role.

73. The Committee could see that between 4 December 2018 and 4 April 2019 the Registrant was listed as the RP on an almost daily basis after which he appears much less frequently as RP, seemingly performing that role for UK Meds on average once a month. The Committee is satisfied that before this frequency tailed off, the Registrant could be described as the regular RP between 4 December 2018 and 4 April 2019.

Particulars 2, 2.1 and 2.2 are found proved.

Particular 3

Between 4 May 2020 and 13 October 2021, you were a director of UK Meds.

74. The Committee had sight of an extract from Companies House which showed that the Registrant was one of four directors of UK Meds who was appointed on 4 May 2020. The same register confirms that the Registrant resigned in the role of director on 13 October 2021.

Particular 3 is found proved.

Particular 4

In relation to paragraphs 1 and/or 2 above:
4.1. in your capacity as RP, you oversaw the dispensing of approximately 43,186 prescriptions including those for controlled and/or non-controlled high-risk medicines and/or medicines requiring ongoing monitoring; and/or
4.2. in your capacity as SI, you oversaw the prescribing of approximately 378,885 prescriptions including those for controlled and/or non-controlled high-risk medicines and/or medicines requiring ongoing monitoring.

75. The Committee has already found that between 24 September 2018 and 4 September 2021 the Registrant was working as a RP for UK Meds. The Committee considered the evidence from AP, Inspection Operations Manager at the GPhC, who explained that when appointed and signed in as the RP, the Registrant would have needed to comply with The Medicines (Pharmacies) (Responsible Pharmacist) Regulations 2008 as well as the Medicines Act 1968 as amended and the Human Medicines Regulations 2021 as amended. Pursuant to section 72A of the Medicines Act 1968 it is the duty of the RP to secure the safe and effective day to day running of the pharmacy so far as it concerns the sale of medicinal products and the supply of such products.

76. The Committee has considered the evidence from the Registrant which accepts that he was employed as a SI at UK Meds between approximately October 2018 and September 2021, when the pharmacy voluntarily removed itself from the register.

77. The Committee considered the evidence of AP who confirmed that this was the Registrant's role within these dates and explained that in accordance with section 71 of the Medicines Act 1968, an SI must be appointed to act for the body corporate where that body corporate owns a registered pharmacy in order for it to lawfully conduct a retail pharmacy business.

78. Section 72AA of the Medicines Act 1968 states that it is the duty of the SI to secure that the pharmacy business is at all times carried on in ways that ensure its safe and effective running so far as it concerns the retail sale of medicinal products and the supply of such products in circumstances corresponding to retail sale.

79. The Committee heard from NR, Senior Clinical Advisor and Specialist Inspector for the GPhC who, on 4 October 2023, was asked to assist MA (Professionals Regulations Manager) with categorising medicines from spreadsheets of prescription data that she had received from UK Meds. Ms NR identified medicines according to those which were higher risk and/or liable to abuse, misuse or overuse – these included

controlled drugs and those that were not controlled but still high risk as they were at risk of being abused, misused or overused, had a risk of toxicity or had a potential to cause serious side effects. She also had a category of drugs which were not necessarily habit-forming or liable to abuse but that had the potential to pose a risk to certain persons in certain situations and/or which might require ongoing monitoring. Ms NR gave clear definitions as to what she considered to be controlled and high-risk medications and medications that required ongoing monitoring in her professional judgment. This was supported by the evidence of GC. The Committee accepted this evidence as reliable and noted that the categories and definitions of high risk/controlled drugs and those requiring ongoing monitoring did not appear to be in dispute.

80. The Committee also heard from SO, a Senior Data Analyst and Insight Manager at the GPhC. He aggregated and analysed a large amount of data from UK Meds, including spreadsheets in respect of prescribing decisions from 32 prescribers. Mr SO told the Committee that he amalgamated this data into one spreadsheet and that within this he identified those categorised by NR as high risk controlled drugs, high risk but non-controlled drugs and drugs requiring ongoing monitoring. These were amalgamated into two spreadsheets with customer names removed which he produced as his exhibits SO/01 and SO/02.

81. The Committee also heard from TM, a Digital Forensics Expert, who analysed the data provided to him by SO (SO/01 and SO/02). Mr TM told the Committee that during his analysis he looked at all the transactions where the Registrant was acting in the capacity of RP, taken from the RP logs, to determine the number of high risk, controlled medicines dispensed during this time, the number of high risk, non-controlled medicines dispensed and the number of medicines which required ongoing monitoring and management which were dispensed during this period. He produced three tables as part of that analysis, which correlated with these three categories of medication. These tables when totalled up, showed that during the Registrant's time as RP, 43,186 high risk and controlled, high risk and non-controlled and medications requiring ongoing monitoring were dispensed.

82. Mr TM also analysed the same data for when the Registrant was acting as SI for UK Meds and within the tables he produced, the Committee could see that during this period (11 October 2018 to 6 September 2021) there were 378,885 high risk and controlled, high risk and non-controlled and medications requiring ongoing monitoring which were prescribed.

83. The Committee is satisfied that in his capacity as RP and SI during these respective dates, the Registrant was overseeing this prescribing as part of his role to the safe and effective running of the pharmacy.

Particulars 4.1 and 4.2 are therefore found proved

Particular 5

5. In relation to paragraph 1 above, you failed to ensure and/or assure yourself that UK Meds and/or its Prescribers were prescribing in accordance with the guidance from the General Medical Council ("GMC"), the Royal Pharmaceutical Society ("RPS") and/or the General Pharmaceutical Council ("GPhC"), in that medicines were routinely prescribed in circumstances where Prescribers had:

5.1. failed to obtain adequate information in relation to the patients' health in advance of prescribing to ensure the supply was appropriate for the patient;

5.2. relied principally on the information received in an online questionnaire;

5.3. 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;

5.4. failed to request a face-to-face or virtual consultation with patients;

5.5. failed to adequately consider the possibility of medication dependence and/or misuse;

5.6. failed to share information about supplies of medicines with other relevant healthcare professional and/or refer patients back to their GP for appropriate assessment and/or review and/or monitoring; and/or

5.7. failed to put adequate safety-netting in place.

84. The Committee has already taken into account the duties of the SI as set out in section 72AA of the Medicines Act 1968, which included securing that the pharmacy business is at all times carried on in ways that ensures its safe and effective running so far as concerns the retail sale of medicinal products and the supply of such products in circumstances corresponding to retail sale.

85. The Committee has considered the GPhC Guidance for Registered Pharmacies providing pharmacy services at a distance, including on the internet (January 2018) ("the January 2018 Guidance") which states that "[t]he pharmacy owner is responsible for making sure this guidance is followed. If the registered pharmacy is owned by a 'body corporate'...the superintendent pharmacist also has that responsibility...Pharmacy owners and superintendent pharmacists should make sure that all staff involved in providing pharmacy services at a distance – including on the internet - are familiar with this guidance. All staff have a responsibility to provide medicines safely to patients and to only do work they are competent to do. We expect this guidance to be followed." The Committee is therefore satisfied that in order to ensure the safe and effective running of UK Meds as a pharmacy business, the prescribers working within that business should be prescribing in accordance with this (and other relevant) GPhC guidance.

86. The RPS Competency Framework July 2016 states that it was published to "support all prescribers to prescribe effectively" and "was developed because it became clear that a common set of competencies should underpin prescribing regardless of professional background". That framework reflects the key competencies needed by all prescribers focusing on how the consultation should be conducted safely and also prescribing governance. The Committee does not intend to repeat all of that guidance here but has had regard to it in considering this allegation.

87. The Committee also heard from GC, an expert within the field of General Practice, who considered the following for her report:

1. GPhC Guidance for Online Pharmacies Providing Service at a distance on the Internet April 2019;
2. GPhC Guidance for Pharmacy Prescribers November 2019;
3. Guidance for Registered Pharmacists – Distance and Internet January 2018
4. In Practice Guidance on Consent GPhC June 2018;
5. RPS Prescribing Competency Framework;

88. She confirmed that whilst she also considered the GMC guidance, this did not necessarily have to be followed by registered pharmacists as it was not directly targeted at them but the Committee considers that this was certainly not the case for the relevant GPhC and RPS guidance which should have been followed where prescribing or overseeing prescribing to the public occurred.

89. The January 2018 Guidance confirms that as part of an initial risk assessment, the pharmacist should get all the information they need from patients to check that the supply is safe and appropriate, taking into account for example their age, gender, other medicines and other relevant issues.

90. GC's report confirms that, in her opinion, a clinician prescribing would be expected to have "*the necessary background clinical information (current physical and mental health, current medication prescribed, current secondary care treatment, investigations and planned follow up)"* and that *"without this clinical information, it is unsafe for a clinician to prescribe any medication"*. She further stated that, in her opinion, "*it is impossible, from a self-populated online questionnaire, for a clinician to get an adequate clinical picture in order to prescribe safely and appropriately"* and that in her opinion, *"the clinician requires access to the medical records or a discussion with the patient's own GP/Specialist as well as potential face to face patient assessment to confirm current physical or mental health, by video-link or, at least by discussion over the telephone".* She further states that in the case of a new medication or an existing one *"the clinician needs to be able to corroborate the self-*

reported clinical information which can only be achieved from accessing medical records and face to face assessment."

91. The Committee had regard to an Improvement Notice issued by the GPhC on 29 March 2019 which stated that patients, their families and GPs had raised concerns about vulnerable patients being supplied with medicines by UK Meds that were clinically inappropriate or excessive in quantity and which had resulted in patient harm or other serious risks to patient safety which prompted the issue of this Improvement Notice.

92. The Committee also had sight of one of these concerns from a witness statement by patient 5's father which was admitted into evidence as hearsay. The concern stated that patient 5 managed to obtain a large quantity of Ibuprofen tablets from UK Meds just before Christmas 2018 which she overdosed on. When questioned by her father, patient 5 told him that she had found UK Meds website and entered details to obtain Ibuprofen. When asked if the website had asked how old she was patient 5 *"said 'yes, all I had to do was tick a box to say I was over 18' or words to that effect. Patient 5 explained that she did not speak with anybody from the pharmacy."*

93. The 29 March 2019 Improvement Notice said that one of the actions for UK Meds to take was that *"all relevant information is obtained from people receiving pharmacy services to check the supply of medicines against a prescription is safe and appropriate to make, taking into account, for example, their age and gender, other medicines supplied and the particular risks associated with the medicine being supplied."*

94. The Committee considered the evidence of RC, an Inspector for the GPhC, who said that he and some colleagues attended a second inspection of UK Meds on 3 September 2019 and that despite initially complying with the Improvement Notice issued by the GPhC on 29 March 2019, UK Meds was still not meeting some of the standards set out in the Standards for Registered Pharmacies 2018 by that date

including that the prescribers were mainly relying on *"answers given by people via a self-reporting questionnaire-based consultation, which cannot provide sufficiently reliable and verifiable information to prescribe safely"* and that "*[t]he pharmacy does not carry out enough checks to make sure that its medicines are appropriate for people".*

95. Mr RC confirmed that an improvement notice was then issued after which there was then a further inspection of UK Meds which took place on 1 November 2019. The Committee considered the report of this second inspection which confirmed there were still failures to obtain adequate information in relation to patient's health before prescribing, for example, it said "[*t]here was very little evidence of contact between the prescribers and the patients. Most contact was a confirmation email; sometimes with a little advice"* and that "*[p]rescribers mainly made their decisions based on information provided in the questionnaire. There was some evidence that prescribers had asked for (and been provided) background information and evidence of scans and treatment…"*

96. The Committee considered the Notice of Conditions, Variation or Revocation which was then issued to UK Meds on 8 November 2019, which said that UK Meds had failed to meet the requirements of a further Improvement Notice issued on 27 September 2019 in that drugs were still being prescribed in circumstances where "*the patient had been asked for additional information, including about diagnostic tests and had not supplied it but a prescription was still issued and a supply of medication made*." Further that there was evidence that "*the pharmacy routinely supplies medicines liable to abuse, overuse or misuse primarily on the basis of a questionnaire with no input from the patient's usual GP or other healthcare provider*". Indeed, the Committee has seen several examples of these questionnaires within the evidence going back to March 2017. The Committee recalls Mr RC saying in his evidence that "*they never mitigated those fundamental risks that were set out in the beginning".*

97. The Committee considers that there is therefore sufficient evidence to say this failure to obtain adequate information and relying principally on information received in an online questionnaire was occurring routinely.

98. On the basis that it has found that prescribing decisions were routinely being made principally on the basis of an online questionnaire, the Committee also finds that medicines were routinely being prescribed in circumstances where prescribers were not requesting a face to face or virtual consultation with patients too. Indeed, from the evidence the Committee heard, there was not even the facility to be able to do this at UK Meds under its model at that time.

Particulars 5.1 and 5.2 and 5.4 are therefore proved.

5.3. 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;
5.5. failed to adequately consider the possibility of medication dependence and/or misuse;
5.6. failed to share information about supplies of medicines with other relevant healthcare professional and/or refer patients back to their GP for appropriate assessment and/or review and/or monitoring; and/or

99. The Committee has considered all of the same evidence above including GC's expert opinion where she states that *"access to a patient's medical records or communication with their GP is a vital step in the consultation process, in order for the prescriber to evidence clinical history and corroborate the self-reported information given in the questionnaire."* She further states that "[*i*]*n my opinion, a Clinician needs to have a full clinical picture prior to issuing a prescription: a current health, past medical and mental health history, addiction history, current medications, past medications, current or past secondary care involvement, results of any investigations or tests and any current monitoring in place or follow up required. This, in my opinion, can only be accessed via patient medical records".* It noted GC's

evidence that prescribers should review medicines where the patient is prescribed a controlled or other medicine that is commonly abused or misused and that where there is not a satisfactory "*2 way discussion between Clinician and patient…there is a risk of inappropriate medication being prescribed (duplicate medication, drugs of potential misuse…)"* and that in her opinion *"a prescriber should be aware of potential misuse of all opiates, needs to be aware of any past or current addiction issues (from the medical records rather than self-reported), needs to keep adequate records in order to check frequency of requests and amounts previously supplied and needs to corroborate any medication requested with the GP or GP records. In my opinion, this can only be achieved once the prescriber is satisfied of the clinical picture, the patient's understanding of potential tolerance and misuse, their clinical presentation and following a full discussion with the patient."*

100. The Committee agrees with and accepts this expert evidence.

101. In the second inspection referred to above that RC attended on 3 September 2019, UK Meds was deemed at that time not to have met some of the standards, namely standard 4.2 including that *"[t]he pharmacy does not ensure that prescribers are proactively sharing all relevant information about the prescription with other health professionals involved in the person's care. And for medicines liable to abuse or misuse, or when there is a risk of addiction and ongoing monitoring is important, it does not have all the additional safeguards it needs. It cannot give assurances that prescribers have always contacted the person's GP in advance of issuing a prescription. And where people have not given consent for their GP to be contacted, it cannot always show that a clear record explaining the clinical justification for prescribing is made".*

102. RC further stated that UK Meds' website offered a service for a large range of treatments and conditions including medicines that had potential for abuse, misuse and overuse and yet during the 3 September 2019 inspection it was found that it *"does not safeguard vulnerable people because it does not have sufficient safeguards to make sure that supplies of medicines liable to abuse, overuse or misuse*

are appropriate. This is because it mainly relies on answers given by people via a self-reporting questionnaire based consultation which cannot provide sufficiently reliable and verifiable information to prescribe safely".

103. By the time of the third inspection on 7 October 2020, there were still concerns that *"[t]he pharmacy cannot show that all risks linked to the supply of medicines online, particularly those that are higher-risk or require ongoing monitoring, have been identified and managed appropriately….[it] doesn't consider all the risks where people do not given authority for the pharmacy to contact their regular prescriber…And opportunities to confirm that the information provided by people is reliable have not always been taken".* It further stated that "*[i]n other examples viewed, where a person had given consent for the pharmacy to contact their GP, the persons' GP was not contacted for additional information and there was no evidence that information about the supply was shared. The prescribing policy stated that prescribers should proactively share all relevant information about prescriptions they issued with other health professionals involved in the person's care. The clinical lead stated that PIPs had the opportunity to contact a GP where consent was given, however no examples of this were provided. Some of the examples seen had been for medicines requiring ongoing monitoring or management. In circumstances where a follow-up is required, communicating a prescribing decision with a person's GP or other healthcare professional involved in their care can help to ensure appropriate and timely monitoring takes place. When asked, the SI said that no additional training had been provided to PIPs about the risks to consider where a patient refused consent to share information with their GP".* The report stated that *"[t]here is no recorded improvement in respect of prescribers accessing patients' GP records and/or specialist clinical records and/or sharing such information with relevant healthcare professionals and/or referring patients back to their GP for review or ongoing monitoring before UK Meds chose to remove itself from the register on 6 September 2021."*

104. Finally, the Committee took note of TM's evidence, which had statistics for the three categories of medicines; high risk and controlled, high risk and non-controlled and

those requiring ongoing monitoring and management and a column that showed on how many occasions the patient's GP was contacted and across all three categories of medicine, this happened on only 8,136 occasions over 378,885 prescriptions.

105. The Committee therefore find that there was a routine failure to access patients' GP medical records but that there was insufficient evidence to say whether they had ever attempted to do this. It also finds that there was a failure to share information routinely with other healthcare professionals and that it failed to adequately consider the possibility of medication dependence and/or misuse.

It therefore finds particular 5.3, 5.5 and 5.6 proved.

5.7. failed to put adequate safety-netting in place.

106. The Committee considered the GPhC In practice: Guidance for pharmacist prescribers (November 2019) which defines 'safety netting' as where the pharmacist tells the person "*that if their condition gets worse, or there are any new symptoms or changes in their condition, to come back to the pharmacist prescriber to make sure no serious conditions are missed*". It also considered the expert evidence of GC who said that *"[i]n the case of self-reported questionnaires, there is no opportunity for the Prescriber to clinically assess or examine the patient, no way to evidence current treatment plans, medication or allergies other than by contacting the patient's GP and no way to ensure follow up, monitoring or safety netting".* She went on to say that *"[i]n my opinion, the self-reported clinical information, (medical and prescribing) is not sufficient for a prescriber to safely prescribe from. In order to safely prescribe a Prescription Only Medicine [POM], the prescriber needs to be aware of the patient's medical and prescription history, have a full clinical picture including the requirement for further patient dialogue or face to face examination, be aware of any previous side effects from prescribed medication, any compliance or misuse of a POM from lack of understanding or capacity of its profile and indication, be aware of the arrangements made for ongoing monitoring, (bloods, blood pressure, weight or response) and provide adequate safety netting".*

107. The Committee was also mindful that because of the UK Meds model, which did not involve face-to-face interaction, the prescriber would be unable to accurately assess the patient's capacity to fully understand any written material sent with the medicine. In addition, in her evidence Dr GC asserted that "*Without a pre prescription discussion...the patient cannot be safety netted or, at least, advised on what to do if the medication does not work, they have side effects, or their condition worsens, and the Clinician cannot be satisfied that this information has been agreed and understood*"

108. The Committee has considered this evidence and opinion carefully and agrees with it. It finds that in light of its conclusions about particulars 5.1, 5.2, 5.3, 5.4, 5.5 and 5.6 above, which evidence routine failings by prescribers whilst under the Registrant's oversight as SI, in particular, no referral of patients back to their GP for further assessment, review or monitoring, there was a failure also by these prescribers (and by the Registrant in accordance with the head of this charge) to put adequate safety netting in place.

Particular 5.7 is found proved.

Particular 6

6. In relation to paragraph 2 above, you dispensed and/or oversaw the dispensing of prescriptions in circumstances where UK Meds prescribing model or service was incapable of supporting safe prescribing decision in that:

6.1. adequate identity checks were not in place;

6.2. no face-to-face or other virtual consultation took place;

6.3. patients provided information primarily through an online questionnaire;

6.4. between approximately, March 2019 and October 2019, the questionnaire at paragraph 6.3 above could be easily manipulated by patients as it highlighted to them answers which could prevent the supply of the medicine and permitted them to change their answers;

6.5. the system did not allow a Prescriber to see if and/or how a patient had changed their answers in the questionnaire pursuant to paragraph 6.4 above and/or;
6.6. patients who had been prescribed the same medicine before through UK Meds were not required to complete another questionnaire for repeat orders.

109. The Committee considered the Improvement Notice dated 29 March 2019 which stated that at the time of that inspection by CC (Regional Manager East), there were concerns about the strength of identity checks carried out at UK Meds before a prescription was supplied to ensure the person receiving the medication was who they claimed to be. This required improvement by 29 April 2019. At the follow up visit on 14 May 2019, there appeared to be 'improvements' made to the identity process, but the Committee notes that this was still something that required further review. The Committee noted that during the evidence of RC, he said that from June 2019 UK Meds did have robust ID checks in place. However, the Committee notes that the Registrant was acting as the RP between 24 September 2018 and 4 September 2021 and that there clearly was a period before the Improvement Notice was issued on 29 March 2019 and before the improvements were made in June 2019 where the identity checks were inadequate.

110. In particular, it notes that on 17 December 2018, a quantity of ibuprofen was dispensed to patient 5, who was under 18 at that time and had managed to obtain this prescription from UK Meds despite this. The Committee therefore accepts that there were clearly inadequacies in the identity checks that were being carried out during this period and indeed, the fact that improvements were subsequently made by UK Meds supports this.

Particular 6.1 is found proved

6.2. no face-to-face or other virtual consultation took place;
6.3. patients provided information primarily through an online questionnaire;

111. The Committee has already heard from GC about the importance of face-to-face and/or virtual consultations as part of safe pharmaceutical practice. The Committee has already considered above at particular 5.4 that there was evidence from the Improvement Notices that prescribers were prescribing where no face to face or virtual consultation was taking place because they were mainly working on the information provided by the online questionnaire. These concerns covered the period when the Registrant was RP between 24 September 2018 and 4 September 2021.

Particulars 6.2 and 6.3 are therefore found proved

6.4. between approximately, March 2019 and October 2019, the questionnaire at paragraph 6.3 above could be easily manipulated by patients as it highlighted to them answers which could prevent the supply of the medicine and permitted them to change their answers;
6.5. the system did not allow a Prescriber to see if and/or how a patient had changed their answers in the questionnaire pursuant to paragraph 6.4 above and/or;

112. The Committee has considered the inspection report dated 3 September 2019 authored by RC, Inspector. It noted the concerns raised about patients primarily providing information via a questionnaire used at UK Meds at this time, which had a *"generic section and then a section that was specific to the medicine that was being supplied. The customer was able to change their answers. If a person gave an answer which meant it was inappropriate for them to have the medicine, the following box appeared 'Based on the answer you've given us, it would be best for you to consult your GP or specialist. You are unable to continue'. The person could then change their answer, which then allowed for the supply of the medicine and they were able to continue with the purchase. The alteration was not auditable and did not flag to the prescriber or pharmacy".*

113. One of the Registrant's colleagues, JS, provided a testimonial on 11 July 2022 which says that the Registrant was instrumental in working closely with UK Meds technical

team to put new automated systems in place to ensure that patients could not circumvent the system going forward.

114. The Committee noted that the Improvement Notice issued on 27 September 2019 directed that by 27 October 2019 the consultation questions *"must not indicate which answers raise questions about whether a medicine is clinically appropriate or allow answers to be subsequently altered without the alteration being visible to the prescriber"*. Further, it notes from RC's evidence that by 7 November 2019 that this action had been met.

115. The Committee has considered all this evidence and accepts that the inspection report recorded what was happening at UK Meds around this time and has no reason to believe it was unreliable. Indeed, it notes that the Registrant must have accepted the questionnaire had these issues as he made efforts to improve it later on. However, the Committee accepts there were indeed such issues for a period of time between approximately March and October 2019.

Particulars 6.4 and 6.5 are therefore found proved.

6.6. patients who had been prescribed the same medicine before through UK Meds were not required to complete another questionnaire for repeat orders.

116. The Committee considered the findings from the GPhC follow up visit to UK Meds on 1 November 2019, which was carried out by CC, RC and NR. They said that the patients who had used the service before could go through a 'reorder' route rather than open a new consultation.

117. The Committee also considered the Induction Pack for UK Meds dated 5 December 2019 which said that the system worked by having prescription requests divided into two sections: *"[t]he first section is named "consultations", and these are very much like a consultation with a patient. The second section of the system related to "orders" and these are very much like a repeat prescription available to the patient*

after a successful consultation for up to a maximum of 6-12 months, shorter times for high risk medicines. Once the cycle of repeat orders is complete, the patient then returns to the initial stage of the cycle, i.e. consultations and the process begins once more."

118. The Committee notes that this reordering process was resolved at a later date by UK Meds as noted from the live evidence of RC, but ultimately there was a period before that where patients were not required to complete another questionnaire for repeat orders.

Particular 6.6 is found proved.

Particular 7

In relation to paragraph 4.2, you ~~dispensed and/or~~ oversaw the prescribing of all or some of the medicines in Schedule A to patients on the basis of a patient completed online questionnaire, when they are unsuitable to be prescribed on that basis.

119. The Committee considered the evidence of TM, who analysed SO/01, on the basis of which Schedule A was produced. Mr TM's analysis revealed that the medications within Schedule A were prescribed between 11 October 2018 to 6 September 2021 which were the same dates that the Registrant was SI. As SI, the Registrant would have been, or certainly should have been, overseeing the prescribing during this period.

120. The Committee has already found at particular 5.2 above, that during this period, medicines were being routinely prescribed in circumstances where the prescribers had relied principally on the information received in an online questionnaire.

121. The Committee has also already found that such prescribing activity was unsuitable and unsafe in accordance with safe prescribing practice and relevant guidance at that time.

Particular 7 is found proved

Particular 8

In relation to paragraph 4.2 above, you oversaw a prescribing system where prescribers knew or should have known that some patients had made one or more previous orders from UK Meds for the same medicines requiring ongoing monitoring and/or medicines which were unsuitable to be prescribed on the basis of a patient completed online questionnaire.

122. The Committee considered the evidence of TM. His statistical analysis showed that during the period from 11 October 2018 to 6 September 2021, when the Registrant was SI and was overseeing the prescribing of medication, there were 2,663 instances of a unique customer being prescribed the same medicine (identified as high risk) more than ten times in any quantity. By virtue of the fact that this medication was high risk, the Committee is satisfied that it would have required ongoing monitoring and that they were unsuitable to be prescribed on the basis of a patient completed online questionnaire.

Particular 8 is therefore found proved.

Particular 9

10. In relation to paragraph 1 above, by the time of the GPhC's visit on 14 May 2019, you failed to ensure that Prescribers made adequate records of their justification for prescribing.

123. The Committee considered the evidence of RC who attended a follow-up visit at UK Meds on 14 May 2019. He said that during that visit, they reviewed medicines which were reaching their 4th request when it should be sent to the clinical lead for a review in accordance with UK Meds' clinical policy. Mr RC said they checked a record

at random which had reached the 4th supply and there was no evidence of prescriber notes to show any reasons for approval.

124. There was no further evidence before the Committee in respect of the adequacy of records being made by prescribers on this date. It therefore does not consider that the one sample Mr RC reviewed was indicative of a failure by the Registrant to ensure prescribers made adequate records of their justification for prescribing.

Particular 9 is therefore found not proved.

Particular 10

10. In relation to paragraph 1 above, by the time of the inspection on 3 September 2019, you failed:

10.1. to ensure that UK Meds had carried out audits to review the safety and quality of the services it provided;

10.2. to ensure that risk assessments were completed by UK Meds;

10.3. to ensure that Prescribers and/or Pharmacists were complying with UK Meds' Standard Operating Procedures ("SOPs") and/or policies;

10.4. to ensure that Prescribers were competent to prescribe in the areas covered by the prescribing service; and/or

10.5. to ensure that Prescribers made adequate clear records of their justification for prescribing in circumstances where a patient did not have a GP or did not consent to share information with their GP.

125. The Committee considered the evidence of RC and the Inspection Report that he produced relating to the inspection on 3 September 2019. This was at a time when the Registrant was acting as SI for UK Meds.

126. Mr RC said that he was concerned that no audits were in place to review the safety and quality of its services meaning that problems with the services may not be identified and resolved quickly. In Mr RC's opinion, this standard was not met. He

gave an example in his report about an in-house clinical audit for asthma having been planned but that this audit had not yet been carried out.

127. The Committee has no reason to believe that Mr RC's notes and opinion about this evidence are not reliable. It found Mr RC to be a helpful and credible witness. It notes that UK Meds Clinical Policy and Procedures stated that regular audits (3 monthly) must take place to ensure that NICE guidelines are being followed when prescribing and that "UK Meds will regularly audit its services for improvement and prescribing habits against NICE guidance".

128. The Committee further noted that the Registrant was present during this 3 September 2019 visit and did not appear to contest this part of the report at the time nor has he suggested since that audits were being properly carried out in accordance with their own policy at this time.

Particular 10.1 is therefore found proved

10.2. to ensure that risk assessments were completed by UK Meds;

129. The Committee has considered the evidence of RC and the inspection report from 3 September 2019, which states that there was no evidence of risk assessments of medicines provided available to the inspectors. As stated already, the Committee considered Mr RC to be a credible witness and his notes of the inspection he carried out to be reliable. It further notes, as above, that the Registrant was present during this inspection and did not appear to contest the finding that risk assessments were not being completed at that time. Although it noted that the need for risk assessments to be completed was then included in the GPhC's Improvement Notice dated 27 September 2019 and the Registrant appears to have emailed the GPhC about this on 26 October 2019.

130. In that email he said that "UK Meds already undertakes numerous risk assessments in respect of the Portal Service and the Dispensing Service and is not aware that any

particular deficiencies have been identified in respect of these services that require rectification". He also attached a number of risk assessments which the Committee has seen. However, it notes that the vast majority of these are undated and the first document entitled Risk Assessment Record is dated 14 October 2019 which post-dates the visit on 3 September 2019. This evidence does not therefore seem to undermine what Mr RC reported which was that by the time of the inspection on 3 September 2019, there was no evidence of risk assessments being completed.

Particular 10.2 is therefore found proved.

10.3. to ensure that Prescribers and/or Pharmacists were complying with UK Meds' Standard Operating Procedures ("SOPs") and/or policies;

131. The Committee has considered the letter from the Registrant's solicitors, Brabners, dated 18 October 2019 whereby it was said that although the inspectors did not see any SOPs produced at the inspection on 3 September 2019, there were SOPs in place and these had been reviewed by the Registrant as SI in June 2019.

132. The Committee has seen some of these SOPs and policies and whilst they may have existed, it does not consider that they were being complied with by the date of this inspection in light of all the evidence it has heard.

133. In light of the Committee's findings in respect of many of these charges, such as particular 5, that prescribers during this time were relying principally on questionnaires, that GPs weren't being routinely contacted when they should have been and that prescribers were failing to adequately consider the possibility of medication dependence and misuse, it is evident that the SOPs and policies the panel has seen in respect of these matters were not being complied with by the prescribers and/or pharmacists.

Particular 10.3 is found proved.

10.4. to ensure that Prescribers were competent to prescribe in the areas covered by the prescribing service; and/or

134. The Committee considered the Inspection Report dated 3 September 2019 which reported that "*[t]he pharmacy couldn't show that prescribers always worked within their areas of clinical competence and expertise. The expected process was that prescriptions were to be sent to PIPs who had relevant areas of clinical expertise and competence."* It further stated that a pharmacy team member had indicated during the inspection that requests for prescriptions were *"randomly assigned and not by speciality"* and that *"PIPs had been reminded not to prescribe outside their competence, but this was not demonstrated from a random example reviewed".* The Committee heard further from RC about this during live evidence, and he confirmed that the contents of the report were an accurate reflection of what they found. The Committee considered Mr RC to be a credible witness and accept that the report findings about the clinical competence of the prescribers was an issue on 3 September 2019.

135. However, it also noted that the Registrant emailed Mr RC on 4 October 2019 to say that he felt this allegation was factually inaccurate because they had identified the training received and areas of competence in respect of the PIPs and that those PIPs who were either not currently trained or who were undertaking training in certain areas were 'blacklisted' for certain treatment areas. The Registrant also said that he told CC during the inspection that they had seen a portfolio of evidence from each prescriber to demonstrate their competencies which was retained and regularly reviewed and he did not simply accept verbal confirmation of this from each prescriber. The Committee notes that in the inspection report dated 3 September 2019, it said that areas of competence and training certificates were held for the PIPs "*but not all information was complete. There was no evidence available to show what areas of prescribing each of the PIPs had specialised in or their scope of competency"* which the Committee finds rather contradictory. It further notes that it has not heard from CC who conducted this inspection to ask about what the Registrant says he told her. Therefore, on the balance of probabilities the Committee

accepts what the Registrant has said about this allegation and that by 3 September 2019 it was more likely than not that he was ensuring that prescribers were competent to prescribe in the areas covered by the prescribing service.

Particular 10.4 is therefore found not proved.

10.5. to ensure that Prescribers made adequate clear records of their justification for prescribing in circumstances where a patient did not have a GP or did not consent to share information with their GP.

136. The Committee considered the evidence of RC and NR who attended the 3 September 2019 inspection. Mr RC said in his evidence that *"[the pharmacy] cannot give assurances that prescribers have always contacted the person's GP in advance of issuing a prescription. And where people have not given consent for their GP to be contacted, it cannot always show that a clear record explaining the clinical justification for prescribing is made".* Ms NR confirmed the same in her evidence: *"Consent to contact a person's GP was being requested by [UK Meds] as part of the questionnaire. However, when consent was provided, prescribers were not always contacting GPs ahead of issuing a prescription for higher risk medicines. When consent to contact a person's GP was not given, medicines were still prescribed and supplied and a justification to support a prescribing decision was not always being recorded".* Whilst the Committee notes the evidence was that this was not always being done, which suggests it must have been being recorded on at least some occasions, it is satisfied that it occurred on a sufficient number of occasions to draw the attention of the GPhC inspectors and be contained within the Improvement Notice dated 27 September 2019 which listed it as a safeguarding concern. Therefore, this suggests that it is more likely than not that the Registrant had failed to ensure prescribers were making adequate clear records of their justifications for prescribing where the patient did not have a GP or did not consent to share information with their GP by this date.

137. As SI during this period, this was an obligation the Registrant had to ensure the safe and effective running of the pharmacy business.

Particular 10.5 is therefore proved.

Particular 11

11. In relation to paragraph 1 above, by the time of the GPhC's visit on 1 November 2019, you failed:

11.1. to ensure that UK Meds had carried out audits to review the safety and quality of the services it provided;

11.2. to ensure that UK Meds' risk assessments addressed the risks associated with its model;

11.3. to ensure that UK Meds Prescribers and/or Pharmacists were complying with UK Meds' SOPs, policies and/or risk assessments;

11.4. to ensure that Prescribers make adequate clear records of their prescribing decisions;

11.5. to ensure that additional information requested by Prescribers was received prior to issuing a prescription; and/or

11.6. to ensure that before issuing a prescription that patients' GPs were given sufficient opportunity to confirm the appropriateness of the proposed supply and/or that monitoring was in place.

11.1. to ensure that UK Meds had carried out audits to review the safety and quality of the services it provided;

138. The Committee considered the GPhC's guidance for registered pharmacies providing pharmacy services at a distance, including on the internet (April 2019) which states that the *"safety and quality of pharmacy services must be reviewed and monitored. You should carry out a regular audit, at an interval that you can show to be appropriate for your pharmacy services. The audit should be part of the*

evidence which gives assurance to people who use your pharmacy that it continues to provide safe pharmacy services."

139. It also reminded itself of UK Meds own Clinical Policy referenced above which stated that it would ensure regular 3 monthly audits in accordance with NICE guidelines.

140. The Committee next considered the evidence of NR who attended a follow up inspection at UK Meds on 1 November 2019 with CC and RC. During that inspection the Registrant was present and admitted that there had been no changes made to the pharmacy SOPs (which had last been reviewed in April 2019) in light of the Improvement Notice. Mr RC reported that during that visit, UK Meds informed the inspectors about 'log rocket' which allowed prescribers to see the interaction patients had with the website, but said that no audit of how often log rocket was being viewed had been undertaken and that *"UK Meds said they had assumed that because incorrect answers were now coming through then people were not changing their responses"* but that no audit of this had been undertaken either.

141. Furthermore, it notes that during that visit, UK Meds was asked *"if a patient decides not to provide consent what information/guidance by UK Meds is there for a prescriber to use to make a decision on whether to prescribe [sic]"*. The recorded response from the Registrant was that "*[t]here is no additional guidance or decision-making tool for this. UK Meds said this was for the individual prescribers to use their professional judgement".* At the end of the meeting, there was a reported conversation with the RP on that date, RG, who allegedly provided very vague responses when asked about prescribers recording justifications for deciding to supply and that *"there was no evidence to suggest this was something that the pharmacy routinely checked for or reported back if this was not being done".*

142. The Committee has carefully considered all of this evidence and has already stated that it found Mr RC to be a credible and reliable witness. It therefore accepts that by the time of the GPhC's visit on 1 November 2019, when the

Registrant was SI, he failed to ensure that UK Meds had carried out audits to review the safety and quality of the services it provided which was something that he should have been doing to ensure the safe and effective running of the pharmacy in his capacity as SI.

Particular 11.1 is therefore found proved.

11.2. to ensure that UK Meds' risk assessments addressed the risks associated with its model;

143. The Committee considered the GPhC's guidance for registered pharmacies providing pharmacy services at a distance, including on the internet (April 2019) which stated that to meet the standards under Principle 1: The governance arrangements safeguard the health, safety and wellbeing of patients and the public, the pharmacy owner is expected to make sure they *"gather evidence about the risks for each individual service, medicine and medical device that you provide at a distance, including on the internet, before you start providing the service".* Such risk assessments should include consideration of the "*risks you have identified and how these will be managed".* If the registered pharmacy is owned by a 'body corporate' as UK Meds was, the body corporate should make sure the SI understands the guidance that should be followed.

144. The Committee then considered the evidence of NR who attended a follow up inspection at UK Meds on 1 November 2019 with CC and RC. She said that in response to the Improvement Notice issued by the GPhC on 27 September 2019, UK Meds had provided 11 risk assessments for medicines and conditions.

145. Ms NR said in her evidence that the risk assessments were not clear as to the actions or considerations of the prescriber if consent to contact the patient's GP was not provided or if the patient was not registered with a GP. The Committee accepts this was indeed a risk associated with the UK Meds model. Ms NR also said there were some gaps in the risk assessments she saw. She gave some examples, including that

some high-risk medications (such as amitriptyline) were not considered and that risks for medicines that required ongoing monitoring, follow up or management had not been fully considered in the prescribing policy in that medicines such as those for cardiovascular or renal conditions or those prescribed for elderly people formed part of the prescribers' training but the clinical lead admitted this was not documented specifically in any policy.

146. The Committee has carefully considered this evidence and found Ms NR to be a credible and reliable witness. It also agrees that the deficiencies she identified in the risk assessments she saw were indeed risks associated with the UK Meds model at that time.

147. The Committee therefore accepts that by the time of the GPhC's visit on 1 November 2019, when the Registrant was SI, he failed to ensure that UK Meds' risk assessments addressed the risks associated with its model.

Particular 11.2 is therefore found proved.

11.3. to ensure that UK Meds Prescribers and/or Pharmacists were complying with UK Meds' SOPs, policies and/or risk assessments;

148. The Committee considered the evidence of NR who attended the follow up inspection at UK Meds on 1 November 2019 with CC and RC. She said that they conducted a sample of 20 prescriptions at random for higher risk items. The Committee asked Ms NR questions about the size of this sample and whether it would have been representative of the issues she found. The Committee was satisfied with her explanation about this. She told the Committee that she requested to see a sample of prescribed and dispensed prescriptions from 30 October 2019. From this, a small proportion (20) of the higher risk prescriptions were selected for further review. She said she felt this was an adequate and fair sample size to assess UK Meds compliance with the Improvement Notice because if there were a high number of failings in even a small sample size, that can be a good indication of their

degree of compliance. She says what she saw in this small sample size was enough to cause them concern.

149. She said that within that sample, compliance with the relevant policies and risk assessments was not always apparent and she gave examples in her statement including, first time prescriptions for opioids and a prescription for the fourth month of opioid medication which were not reviewed by UK Meds' pain specialist despite a policy which stated that such a review should have taken place.

150. The Committee found the evidence of Ms NR to be credible and reliable. It has seen no reason to doubt the evidence she gave.

Therefore particular 11.3 is proved.

11.4. to ensure that Prescribers make adequate clear records of their prescribing decisions;

151. In NR's evidence, the Committee noted that at the 1 November 2019 inspection, there were concerns about the record-keeping in respect of prescribing decisions. She said that on some occasions when the medication had been supplied in the absence of consent to contact the patient's GP, UK Meds had provided some justification but there were examples were no justification was provided. She also said that where justification for the prescribing decisions were present, they varied in detail and in some cases, they were weak as the justifications did not demonstrate recording of clinical or patient-centred information. She gave some examples of such weak justification in her evidence. She said that the records for prescribing decisions were not clear and that if another prescriber was to provide care at a future date, they would not have had a clear understanding of the original prescriber's thought process. Ms NR said that even though their report records that in 12 out of 14 cases these decisions were recorded, it was the quality that was the issue and that they weren't adequate for another prescriber to see why the prescription had been issued. Ms NR said that in her professional opinion this was a

failing by both the prescriber and the SI/clinical lead whose roles in governance are to review and monitor this.

152. The Committee found Ms NR to be a credible witness and found her evidence to be reliable. It further notes that during this period, the Registrant was SI and responsible for the safe and effective running of the pharmacy. It therefore finds that by 1 November 2019, the Registrant had failed to ensure that prescribers were making adequate clear records of their prescribing decisions.

Particular 11.4 is found proved.

11.5. to ensure that additional information requested by Prescribers was received prior to issuing a prescription; and/or

153. The Committee considered the evidence of RC who produced an email as his exhibit dated 11 November 2019 which contained contemporaneous notes from the GPhC's Enforcement Action Meeting on 7 November 2019. Those notes stated that *"[t]here were many instances of patients on multiple regular orders. There were occasions where the prescriber had requested additional information but had issued a prescription regardless without receiving that additional information."* This was then incorporated into the Notice of Conditions, Variation or Revocation which was issued to UK Meds by the GPhC on 8 November 2019 which reiterated that *"[t]here were some cases where the patient had been asked for additional information, including about diagnostic tests, and had not supplied it but a prescription was still issued and a supply of medication made which presented a serious risk to patient safety".*

154. As the Registrant was SI and responsible for the safe and effective running of the pharmacy during this time and certainly was by 1 November 2019, the Committee is satisfied that the Registrant had failed to ensure that additional information requested by Prescribers was received prior to issuing a prescription.

Particular 11.5 is therefore found proved.

11.6. to ensure that before issuing a prescription that patients' GPs were given sufficient opportunity to confirm the appropriateness of the proposed supply and/or that monitoring was in place.

155. Ms NR also gave evidence to the effect that in some samples seen, when the patient had consented for contact to be made with the GP, UK Meds only gave 1 day for the GP to respond to any correspondence. In the absence of a response, she said the medicine was still supplied which meant that high risk medication, which is liable to abuse, misuse and overuse, was supplied without confirmation from the patient's GP that the supply of the medication would be appropriate.

156. As stated previously, the Committee found Ms NR to be a credible witness and it accepts her evidence as reliable. In light of the Committee's findings that the Registrant was SI at this time and as previously stated, responsible for the safe and effective running of the pharmacy at this time, the Committee is satisfied that the Registrant failed to ensure that before issuing prescriptions, that patients' GPs were given sufficient opportunity to confirm the appropriateness of that.

Particular 11.6 is found proved.

Particular 12

12. In relation to paragraph 1 above, by the time of the inspection on 7 October 2020, you failed:

12.1. to ensure that UK Meds implemented SOPs and/or policies to review the quality of the services it provided;

12.2. to ensure that UK Meds prescribing policies addressed the risks of the medicines it supplied;

12.3. to ensure that UK Meds had carried out risk assessments for medicines it supplied;

12.4. to ensure that UK Meds' prescribing service considered all the risks when patients did not provide authority and/or consent to contact their regular Prescriber/ GP;

12.5. to ensure Prescribers made adequate clear records of their prescribing decisions; and/or

12.6. to ensure that Clinical Leads regularly reviewed Prescribers' decisions.

12.1. to ensure that UK Meds implemented SOPs and/or policies to review the quality of the services it provided;

157. The Committee considered the evidence of RC who attended UK Meds further inspection on 7 October 2020. That inspection recorded that whilst there were some policies in place, they were not fully addressing the risks associated with the model. For example, the pharmacy's prescribing policy *"did not fully address all the risks associated with the medicines it supplied. The scope of those medicines identified as being 'high risk' was limited to codeine, dihydrocodeine, co-codamol, zolpidem and zopliclone" which were not currently being supplied by UK Meds. The policy did not recognise all the categories of medicines that are not suitable to be supplied online unless further safeguards have been put in place to make sure they are clinically appropriate."*

158. Furthermore, the prescribing policy was said to include consideration of communication between PIPs, the pharmacy team and the customer services team and included information about gaining consent to contact a person's GP but that when the inspectors reviewed some prescriptions on 7 October 2020 visit, even though people had given their consent for their GP to be contacted, there "*was no evidence to show that this happened".*

159. The Committee also saw evidence from this inspection that whilst there was a set of up-to-date SOPs which reflected the pharmacy services of dispensing and supply, there was evidence that suggested this was not always being complied with: *"The pharmacy had separated the picking and assembly functions so that there was an*

additional check while dispensing medicines. The pharmacy used a dispensing audit trail which included a record of the person who had picked the medicine and the use of dispensed by and checked by boxes on the medicine label. When checked, the person who dispensed the medicine annotated the picking note to show who had picked the medicine. This didn't comply with the SOP."

Particular 12.1 is therefore proved.

12.2. to ensure that UK Meds prescribing policies addressed the risks of the medicines it supplied;
12.3. to ensure that UK Meds had carried out risk assessments for medicines it supplied;

160. The Committee has considered the evidence of RC, who attended a reinspection on 7 October 2020 and his report of the findings at that inspection which the Committee accepts is a contemporaneous document as it was drafted around the same time of the inspection. The Committee found Mr RC to be a credible witness. He gave evidence that each element of the service that the pharmacy provided had not been adequately risk assessed and that the pharmacy did not have current risk assessments for each medicine it was supplying – the only risk assessments they had were for high-risk medicines which were not currently supplied. Mr RC said this was an area that had been identified on previous occasions but still not addressed and the Committee heard that UK Meds had had longer than usual to address these issues because there was a delay in the reinspection due to Covid.

161. Mr RC also said that the pharmacy's prescribing policy did not fully address all the risks associated with the medicines it supplied. The medicines identified as being high risk were limited to certain drugs only, but none of those medicines were currently supplied. The policy did not recognise all the categories of medicines that are not suitable to be supplied online unless further safeguards had been put in

place to make sure they were clinically appropriate, nor did it include those medicines which could be particularly dangerous in overdose, such as amitriptyline.

162. The Committee has had sight of the prescribing policy and some of the risk assessments (opioids and z-drugs) and agrees with the criticisms made in Mr RC's inspection report from 7 October 2020. In particular, it notes that there does not appear to be any policy for drugs such as amitriptyline as Mr RC stated in this report.

Particulars 12.2 and 12.3 are therefore found proved.

12.4. to ensure that UK Meds' prescribing service considered all the risks when patients did not provide authority and/or consent to contact their regular Prescriber/ GP;

163. The Committee considered the UK Meds prescribing policy which said at 5.1 that if prescribers were considering prescribing a high risk medicine, *"the patient **must** have provided their consent for the prescriber to contact their GP; the patient **must** have provided their GP's contact details; the prescriber **must** contact the patient's GP and obtain the GP's confirmation that the proposed prescription for a high risk medicine is appropriate and that the prescriber **must** put in place appropriate monitoring procedures for the patient and inform the patient's GP of the same".* The Committee thought this was a robust policy, however, in light of the other evidence it has heard and seen in this case, it does not consider this was always being followed by prescribers when it should be. It also noted that the same concerns were raised in the inspection report from 7 October 2020 which stated that when asked *"the SI said that no additional training had been provided to PIPs about the risks to consider where a patient refused consent to share information with their GP".*

Particular 12.4 is therefore found proved

12.5. to ensure Prescribers made adequate clear records of their prescribing decisions; and/or

164. The Committee considered the evidence of NR who attended the 7 October 2020 inspection and also said that prescribing decisions were not always recorded adequately. She also said that evidence of the prescribing review was shared by UK Meds where the clinical lead had contacted the prescriber using a communication system however a daily record of the number of interventions the clinical lead made was not maintained and no other reviews of the prescribing service were being carried out.

165. The Committee also considered the inspection report which said that based on a small sample of the records that were reviewed showed that the record keeping by the PIPs was inadequate. Whilst the clinical lead stated that all prescribing decisions required a justification but that in the sample of prescriptions on that day, not all the prescribing records had a justification recorded. Some were very brief or had reasons that lacked any substance. It is noted also that the Registrant was spoken to at this inspection about this and "*accepted that the justification for supply and the notes made by the PIPs could be improved and stated that feedback would be provided to the PIPs"*.

Particular 12.5 is therefore found proved

12.6. to ensure that Clinical Leads regularly reviewed Prescribers' decisions.

166. The Committee considered the inspection report from 7 October 2020 which said that one of the clinical leads felt there was robust oversight of the prescribing process "*[b]ut some of the evidence found during the inspection did not reflect this."* However, the report states that "*[o]ne of the clinical leads managed around 20 to 30 requests a day that the prescribers had referred to him because they wanted some advice or further information was required...They looked at most prescriptions every day as part of their review of the other PIPs. Approximately five to ten per day of these were said to have required some level of review. Feedback by the clinical leads to the other PIPs was given via Slack".* The criticism in the report appears to be

that a daily record of the number of interventions was not maintained and that no other reviews of the prescribing service were currently being carried out. When asked about this during her evidence, Ms NR said that because there was little or no justification of prescribing decisions, the clinical lead was unable to review these effectively. However, in respect of whether the Registrant had failed to ensure that clinical leads were regularly reviewing these decisions, the Committee does not find the burden of proof has been discharged here. Whilst it accepts there may have been issues with record-keeping by the clinical leads, there was some evidence that the clinical leads were reviewing the prescribers' decisions.

Particular 12.6 is therefore not proved.

Particular 13

13. In relation to paragraph 1, you failed to implement changes to improve the safety of UK Meds' operating systems and processes as set out in the Improvement Notices dated 27 September 2019 and 30 November 2020.

167. The Committee considered the Improvement Notice dated 27 September 2019 which stated that by 27 October 2019, UK Meds had to take the following measures:

a. complete a risk assessment for each part of the service and the medicines supplied and ensure that regular review audits of risks identified and reactive review audits were carried out;
b. [redacted]
c. The consultation questions must not indicate which answers raise questions about whether a medicine is clinically appropriate or allow answers to be subsequently altered without the alteration being visible to the prescriber;
d. You must ensure that the prescribers you work with work in accordance with the relevant GPhC guidance to proactively share all relevant information about the prescriptions they issue with other health professionals involved in the care of the patient (for example their GP); that the prescriber contacts the GP in

advance of issuing a prescription to confirm that the prescription is appropriate for the patient and that appropriate monitoring is in place; that the prescriber makes a clear record setting out their justification for prescribing, in circumstances where the patient does not have a GP or does not consent to share information.

168. The Committee also considered the Improvement Notice dated 30 November 2020 which stated that by 11 January 2021:

a. You must complete a risk assessment that covers each individual service the pharmacy provides at a distance. The risk assessment must be documented and should identify each of the medicines you are supplying and the conditions they are being used to treat. As part of your risk assessment you must identify which medicines require further safeguards to be put in place to make sure that they are clinically appropriate and that suitable safeguards are in place;
b. You must put in place and implement clear procedures for the pro-active and regular review of the quality of services you are providing with regard to the prescribing and supply of medicines. You will need to provide evidence of these procedures, showing that they are embedded within the pharmacy working processes, with specific reviews and audits scheduled at intervals which you can show to be appropriate to the risks identified in your risk assessment in action 1;
c. You must put in place and implement clear procedures for all medicines which required further safeguards to be put in place, such as those that require monitoring and ongoing management, as identified in your risk assessment in action 1. These must cover the additional risks where the person does not have a regular prescriber such as a GP, or if there is no consent to share information;
d. You must ensure that clear judgements are recorded for all prescribing decisions whether or not a medicine is supplied;
e. You must ensure that where a person has given consent, your prescribing service proactively shares all relevant information about the prescriptions they issue with other health professionals involved in the care of the patient (for example their GP)

169. The Committee considered the evidence of RC who said that on 31 October 2019 he and other colleagues attended an enforcement action meeting where it was agreed that there was insufficient evidence that the changes had been implemented. On 7 November 2019, Mr RC attended a further enforcement meeting, where it was unanimously agreed that action 'C' of the 27 September 2019 Improvement Notice was met but that it had failed to comply with the other terms of the Notice.

170. Due to the delays with Covid, a further inspection was carried out on 7 October 2020 after which the 30 November 2020 Improvement Notice was issued. Mr RC said that on 24 March 2021, he sent a letter to UK Meds informing them they had failed to comply with all five actions set out in the 30 November 2020 Improvement Notice.

171. Based on all the evidence the Committee has seen and heard in this case, it accepts the reliability of this evidence and the failure by the Registrant to implement changes in these Improvement Notices – the Committee accepts that one change was made in that both Mr RC and NR accepted the amendments made to the questionnaire was a satisfactory improvement – but ultimately, there remained changes that were not implemented which as SI, the Registrant had an obligation to do to ensure the pharmacy services were safe.

Particular 13 is found proved

Particular 14

14. In relation to paragraph 1 above, you failed to identify that Prescribers were prescribing medicines liable to misuse and/or abuse to vulnerable patients, including to:

14.1. Patient 1;
14.2. Patient 3; and/or
14.3 Patient 13.

Patient 1

172. As SI at the relevant time, the Committee has already found that the Registrant had certain responsibilities in respect of overseeing the safe and effective running of the pharmacy.

173. The Committee has considered the evidence of patient 1's medical record spreadsheet which shows that on 29 January 2021, patient 1 ordered 84 amitriptyline 50mg tablets from UK Meds which was approved on the same day and delivered.

174. The Committee considered the evidence of JK who the Committee found to be a credible and reliable witness. He said that patient 1 came into the Accident and Emergency Department on 30 January 2021 having taken an overdose of amitriptyline. Paramedics had found a number of empty medication boxes together with a dispensary note from UK Meds. He confirmed that having reviewed patient 1's medical notes (which were also supplied to the Committee), she was clearly vulnerable and had taken overdoses on previous occasions. He also confirmed that amitriptyline was a high risk medication liable to misuse and abuse and that patient 1 was very lucky to have survived, particularly as she was very slim.

Particular 14.1 is therefore found proved

Patient 3

175. The Committee considered the evidence in respect of patient 3 which includes hearsay evidence being a referral to the GPhC by DR who expressed concerns that patient 3 had managed to purchase dihydrocodeine on four occasions from UK Meds when this was "entirely inappropriate" as she had an addiction and was on a reducing regime. Dr DR said that on only one occasion had she been notified. The Committee is aware that dihydrocodeine is a medicine that is high risk and liable to misuse and/or abuse and that patient 3 was a vulnerable patient.

176. The Committee has treated this evidence with caution because it is hearsay evidence, however, it finds it to be persuasive and credible in that it is from a professional reporting a concern in her capacity as this patient's GP. It is also corroborated in part by evidence from the Registrant's solicitors.

177. The Committee saw the prescribing records for patient 3 produced by the Registrant's solicitors on 9 October 2020. These showed 16 prescription requests made by patient 3 to UK Meds during the time that the Registrant was SI – 11 of these were marked as 'complete' or 'delivered' and only four marked as 'refused' and one marked as 'closed'.

178. It should be added that the Committee checked with Mr Hoskins when it started considering this particular whether or not it had been included within the hearsay application he made previously as it noted that patient 3 did not appear to have been included. Mr Hoskins confirmed that this evidence was supposed to have been part of that application but that it had been an oversight on his part that it had not been. He asked for this evidence (that is the referral made by Dr DR) to be retrospectively added to that hearsay application. The Committee carefully considered this in respect of the principles set out in *Thorneycroft* and in line with its considerations of this second category of evidence previously and is content that it is relevant and fair to admit this evidence.

Particular 14.2 is found proved.

Patient 13

179. The Committee saw the evidence of a prescription by a prescriber at UK Meds dated 14 June 2021 issued to patient 13 for 84 tablets of Propranolol 40mg. It also considered the evidence of EC which was the subject of a hearsay application by the GPhC as referenced above. She gave an account from the parents of patient 13 who said that on 19 June 2021, they received a phone call from Prestwich Hospital saying

that patient 13 had taken something and her heart had stopped and she was on her way to A&E. She sadly passed away and had taken an overdose of propranolol tablets which had been prescribed to her. The Committee has treated this evidence with caution because it recognises that it is multiple hearsay but as stated previously, it considers it to be quite reliable in light of EC's professional role as a police officer in taking this report. The Committee is also quite clear from reviewing this statement that patient 13 was a vulnerable young lady who, by her history, was liable to misuse or abuse medication such as propranolol, which the Committee is aware is a high risk medicine.

Particular 14.3 is therefore found proved.

15. In relation to paragraph 1 above, between approximately 11 October 2018 and 26 October 2019, you oversaw the prescribing in circumstances where, on 97,599 occasions, the time taken by the Prescriber to consider the prescription would not have been sufficient for the Prescriber to clinically evaluate the suitability of the high risk medication and/or medication requiring ongoing monitoring for the patient including:

15.1. read, consider, and assimilate the patient completed online questionnaire; 15.2. consider if it was clinically necessary to check with the patients' GP and/or contact their GP;

15.3. consider if it was clinically necessary to contact the patient and/or conduct a face-to-face or virtual consultation with the patient; and/or

15.4. consider if it was necessary to check the clinical background of the patient.

180. The Committee considered the evidence of TM, who analysed the data in respect of a period between 11 October 2018 to 26 October 2019 when the Registrant was SI of UK Meds. He identified 97,599 transactions within these dates where the medicines were high-risk and were reviewed by a prescriber who had made their previous prescribing decision within less than one minute. The information on which he based this analysis was contained within exhibit SO/01 which the Committee has reviewed.

181. The Committee has considered whether less than 1 minute would have been sufficient time for a prescriber to read, consider and assimilate the patient's completed online questionnaire and found that it would not have been. Indeed, the Committee has had sight of some of these questionnaires within the evidence and can see that to read, consider and assimilate the information within should have taken a prescriber much longer than this. It is certainly not, in the Committee's opinion, sufficient time for a prescriber to clinically evaluate the suitability of high-risk medication or medication which required ongoing monitoring.

182. It goes without saying that the remaining allegations of considering if it was clinically necessary to check with the patient's GP and/or contact their GP, considering if it was clinically necessary to contact the patient and/or conduct a face-to-face or virtual consultation with the patient or considering whether it was necessary to check the clinical background of the patient would also not have been given sufficient time in less than one minute.

183. The Committee has borne in mind the evidence of GC which describes how safe prescribing should involve a two-way dialogue in a consultation, an assessment of the patient and their circumstances, their clinical background, access to their clinical records to name just a few matters. The Committee also considered the Royal Pharmaceutical Society Competency Framework for all prescribers (2016) which confirmed that before prescribing various factors should be taken into account including taking an appropriate medical, social and medication history, including allergies and intolerances, undertaking an appropriate clinical assessment and accessing and interpreting all available and relevant patient records to name just a few. The Committee does not consider that any of this can be carried out in less than one minute.

Particular 15 in its entirety is therefore found proved.

Particular 16

16. In relation to paragraph 2.1 above, on 12 September 2019, you dispensed and/or oversaw the dispensing of 100 tablets of codeine 30mg to Patient 2, a patient with a history of poor mental health and/or opioid dependence, in circumstances where you had not assured yourself that it had been prescribed in accordance with the relevant guidance from the GMC, RPS and GPhC, in that it was prescribed in circumstances where the Prescriber had:

16.1. failed to consider that the patient had already made one or more previous orders from UK Meds;

16.2. failed to obtain adequate information in relation to the patient's health in advance of prescribing;

16.3. relied principally on the information received in a patient completed online questionnaire;

16.4. failed to access and/or attempt to access the patient's 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/misuse history;

16.5. failed to request a face-to-face or virtual consultation with the patient;

16.6. failed to adequately consider the possibility of medication dependence and/or misuse;

16.7. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring; and/or

16.8. failed to put adequate safety-netting in place.

16.1

184. The Committee has considered the Pharmacy Record which shows that on 12 September 2019, the Registrant was the Responsible Pharmacist at UK Meds. As RP, the Registrant's role was to secure the safe and effective running of the pharmacy when operational. In doing so, he was either dispensing or overseeing the dispensing on that day.

185. The Committee has also seen a printout of the prescribing records relating to patient 2 which show that on 12 September 2019, she made an order for codeine 30mg 100

tablets which was completed by one of the prescribers. The printout also shows that previously, patient 2 had made a request for modafinil on 19 June 2018, codeine on 28 June 2019 (which was refused) and zopiclone 7.5mg on 17 August 2019 which was dispensed by a different pharmacy (Tower pharmacy).

186. It also noted that the Registrant said via his solicitors that "*[a]t the time of dispensing (17.12.2018) the pharmacy's checking dashboard did not display details of orders that had previously been placed by the website or the patient's answers to the current (or any previous) clinical questionnaire and so I only had sight of the prescription that had been approved and issued by the prescriber* ***together with the information that was contained in the pharmacy's patient medication record (PMR) which showed details of items that the pharmacy had previously dispensed to the patient***".(Our emphasis) Whilst this was the Registrant's account as to what he could see in December 2018, the Committee considers this was sufficiently close in time to these orders made by patient 2 and there is no indication that this model had changed by September 2019.

187. Whilst the Committee accepts that there is no evidence that these previous orders were considered by the prescriber before prescribing this medication, it is not persuaded that the RP as someone overseeing the *dispensing* of this prescription would have had knowledge or sight of whether the prescriber had considered these previous orders or not and that there had been a previous refusal.

188. This is because the evidence from the Registrant's solicitors referred to above suggests that the RP, as the person either dispensing or overseeing the dispensing of the prescription on this date, would have had access to the dispensing PMR but not necessarily the prescribing PMR. The Committee understands that the dispensing PMR may not have included prescriptions dispensed by other pharmacies (such as that on 19 August 2019 – Zopiclone dispensed by Tower pharmacy) nor any prescription requests that had been refused (such as the codeine on 28 June 2019). Therefore, the only previous request that the RP would have had sight of in respect of this 12 September 2019 order was the previous dispensing of modafinil on

19 June 2018 which is a different drug and so may not have raised any particular red flags.

189. As such, it does not believe that it was fair to suggest that the RP should have or could have assured himself that the prescribing had occurred in circumstances where the prescriber had considered these previous orders (and previous refusal) made by the patient. He would not have necessarily had sight of all of this information and therefore it is an obligation on the RP which the Committee considers to be unfair.

Particular 16.1 is therefore found not proved.

16.2. failed to obtain adequate information in relation to the patient's health in advance of prescribing;
16.3. relied principally on the information received in a patient completed online questionnaire;
16.4. failed to access and/or attempt to access the patient's 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/misuse history;
16.5. failed to request a face-to-face or virtual consultation with the patient;
16.6. failed to adequately consider the possibility of medication dependence and/or misuse;

190. The Committee considered the statement of patient 2's mother, the coroner's report and letter dated 8 March 2021 which confirmed that patient 2 had a history of opiate addiction and that the inquest established that neither a doctor nor any dispensing pharmacist checked with the registered GP whether it was appropriate to dispense these prescriptions which included opiate medication. The letter from Acting Senior Coroner AC goes on to say that "[*h]ad any check been made, it would have been established that [patient2] had an opiate addiction and had been struck off the Nursing Register for forging prescriptions obtained during her work as a Practice Nurse".*

191. The Committee also considered a request from the GPhC to UK Meds asking for the PMR for patient 2 and in particular, "*[e]vidence of all communication with the patient and the patient's GP".* The response from UK Meds to this was "[*n]o such item exists and/or no communication recorded".*

192. The Committee considers that this evidence shows that it is more likely than not that the prescribing decision on 12 September 2019 happened in circumstances where the prescriber failed to obtain adequate information about the patient's health in advance of prescribing and failed to access or attempt to access the patient's GP records in order to have a full picture of their physical or mental health and failed to adequately consider the possibility of medication dependence and misuse. Indeed, had this information been requested and/or considered by the prescriber, the Committee considers it unlikely that opiates would have been prescribed for this patient because of her previous medical history which was highly relevant.

193. Furthermore, the Committee is satisfied that the UK Meds model at that time was that information was principally being relied upon from a self-completed questionnaire and that there was no facility within this model to allow for a face to face consultation at this time. The practice was clearly that prescribers were relying principally on these questionnaires and the Registrant was well aware of this. He therefore should have only dispensed or overseen the dispensing on that day if he had been able to assure himself that it had been prescribed in accordance with the relevant guidance from the GMC, RPS and GPhC, which it had not.

Particulars 16.2, 16.3, 16.4, 16.5 and 16.6 are therefore found proved.

16.7. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring; and/or
16.8. failed to put adequate safety-netting in place.

194. The Committee has considered the evidence from UK Meds in respect of the prescription records of this patient. This has a list of the prescription requests made by patient 2 and includes a box for 'comment' by the prescribers. On 12 September 2019, there are 4 entries which seem to suggest the order was made by patient 2 at 13:02 and given a status of 'processing'. The comments box then says the order was "referred by ip stacy (SK)" with a status of 'clinical review' at 13:04. The Committee believes this was when the PIP referred the order to the clinical lead as the prescription was then processed an hour later at 14:05 by the prescribing pharmacist.

195. The Committee notes also that when patient 2 makes a further request for codeine on 18 October 2019, the comments box says 'Codeine is not advisable long term for muscular pain. Please try a short course of naproxen if tolerated and follow up with your GP. Thank you'. This suggests that on that occasion, there was a referral back to the GP but on 12 September 2019 there is no such evidence this happened. Indeed, the Committee notes that the coroner's letter referred to a lack of GP contact or referral to them after this prescription was provided. It is notable also that there is no evidence of safety-netting or indeed, any follow up taking place. The Committee considers that if this had happened these notes would have been on this prescription record. It therefore considers it more likely than not that there was a failure to refer this patient back to their GP for appropriate assessment and/or review and/or monitoring and/or failed to put adequate safety-netting in place.

196. As the Committee has already found, the Registrant as RP on that day should have assured himself that the medication had been prescribed in accordance with this good practice and the relevant guidance from the GMC, RPS and GPhC and had not.

Particulars 16.7 and 16.8 are therefore found proved.

Particular 17

17. In relation to paragraph 2.2 above, on 19 December 2018 and 11 March 2019, you dispensed and/or oversaw the dispensing of modafinil, dihydrocodeine and pregabalin to Patient 4, a patient with a history of poor mental health, overdose and/or self-harm, in circumstances where you had not assured yourself that it had been prescribed in accordance with the relevant guidance from the GMC, RPS and GPhC, in that it was prescribed in circumstances where the Prescriber had:

17.1. failed to consider that the patient had already made one or more previous orders from UK Meds;

197. The Committee has considered the Pharmacy Record and its findings in respect of particular 2.2 which shows that the Registrant was acting as the regular RP on 19 December 2018 and 11 March 2019.

198. Similar to the Committee's previous findings in respect of particular 16.1, the Committee is not satisfied that the Registrant would have been in a position to either know what the prescriber might have considered or had not considered in respect of this prescription, nor would have had knowledge or sight himself of whether the prescriber had considered these previous orders or not. This is because, as stated previously in its findings on 16.1 above, the Registrant would not necessarily have had sight of the prescribing PMR as the RP; rather he would likely have only been able to see the previous orders that were *dispensed* by UK Meds.

199. In respect of patient 4, there were two previous orders for zopiclone which, as a different drug, the Committee does not necessarily think would have been a relevant previous order for the prescriber to consider and the previous orders for pregabalin on 3 June 2018 and 14 January 2019 were either refused or issued by a different pharmacy (therefore would not have shown in the dispensing PMR). There was one previous order for dihydrocodeine which the Committee accepts would have been relevant but it does not, on balance, think this would necessarily have raised any red flags for the prescriber or RP as it was a single order.

200. As such, it does not believe that it was fair to suggest that the RP should have or could have assured himself that the prescribing had occurred in circumstances where the prescriber had considered these previous orders made by the patient. He would not have necessarily had sight of this information and therefore it is an obligation on the RP which the Committee considers to be unfair.

Particular 17.1 is therefore not proved

17.2. failed to obtain adequate information in relation to the patient's health in advance of prescribing;
17.3. relied principally on the information received in a patient completed online questionnaire;
17.4. failed to access and/or attempt to access the patient's 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/misuse history;
17.5. failed to request a face-to-face or virtual consultation with the patient;
17.6. failed to adequately consider the possibility of medication dependence and/ or misuse;
17.7. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring; and/or
17.8. failed to put adequate safety-netting in place.

201. The Committee has considered the remaining allegations in particular 17 together, insofar as they relate to the dispensing or oversight of dihydrocodeine and pregabalin as the Committee has not seen any evidence on these dates in respect of modafinil.

202. It has seen evidence of prescriptions issued to patient 4 for 100 tablets of dihydrocodeine 30mg on 19 December 2018 and 56 capsules of pregabalin 150mg on 11 March 2019.

203. It has also considered the report of LF, Consultant Psychiatrist, which was the subject of a hearsay application by the Council previously. The Committee has treated this evidence with some caution and borne in mind that it is hearsay evidence with the limitations that accompany that. It notes, however, that this report would have been prepared in accordance with Dr LF's professional role as consultant psychiatrist and therefore is likely to be reliable. That report confirmed that patient 4 had a history of poor mental health including overdose and self-harm.

204. The Committee found that, for similar reasons to its findings in respect of patient 2 at particular 16, that the evidence shows that it is more likely than not that the prescribing decisions on 19 December 2018 and 11 March 2019 happened in circumstances where the prescriber had failed to obtain adequate information about the patient's health in advance of prescribing and failed to access or attempt to access the patient's GP records in order to have a full picture of their physical or mental health. It says this because had this information been requested and/or considered by the prescriber, the Committee considers it highly unlikely that these medicines would have been prescribed for this patient, given their considerable history of mental health issues.

205. Furthermore, the Committee is satisfied that the UK Meds model at that time was that information was principally being relied upon from a self-completed questionnaire and that there was no facility within this model to allow for a face to face consultation at this time. The practice was clearly that prescribers were relying principally on these questionnaires and the Registrant was well aware of this. He therefore should have only dispensed or overseen the dispensing on that day if he had been able to assure himself that it had been prescribed in accordance with the relevant guidance from the GMC, RPS and GPhC, which it had not.

206. Furthermore, the Committee is already aware that dihydrocodeine and pregabalin were medicines liable to misuse and medication dependence. This is something that the prescribers and dispensing pharmacist should have been alive to. In light of the Committee's findings above that it is more likely than not that the prescriber failed

to obtain adequate information about patient 4's health in advance of prescribing, which had they done so would have revealed that this patient had a history of overdose and very poor mental health. It therefore finds that it is more likely than not that the prescribers on 19 December 2018 and 11 March 2019 failed to adequately consider the possibility of medication dependence and/or misuse for this patient.

207. The Committee has considered the prescription requests of this patient and correspondence between the GPhC and the patient's GP surgery. There is no evidence within this documentation to suggest that when these medicines were prescribed, the patient was referred back to the GP for appropriate assessment, review or monitoring or that any safety-netting was put in place for this patient. Indeed, neither the GP surgery nor the Registrant's consultant psychiatrist appeared to have had contact with the patient around these dates concerning assessment, review, monitoring or safety-netting as a result of a referral by UK Meds. Rather, the evidence the Committee has seen suggests that the prescriptions (of which there were many) were simply issued by UK Meds without any further follow up or review or guidance about safety-netting given. In particular, the Committee notes that there is a request by the GPhC asking for *"copies of all clinical review notes/comments made in relation to all supplies made to this patient and state who made them"* and the response from UK Meds was that "*[n]o such item exists and/or none recorded"*. The Committee has carefully considered these two particulars and finds that, on the balance of probabilities, having seen how the UK Meds model appeared to operate at this time, it was more likely than not that there was no referral of this patient back to their GP for appropriate assessment, review or monitoring nor any adequate safety-netting put in place.

208. As the Committee has already found, the Registrant as RP on these days should have assured himself that the medication had been prescribed in accordance with this good practice and the relevant guidance from the GMC, RPS and GPhC and had not.

Particular 17.2-17.8 are therefore found proved.

Particular 18

18. In relation to paragraph 2.2 above, on 17 December 2018, you dispensed and/or oversaw the dispensing of 84 tablets of ibuprofen 600mg to Patient 5, a patient with a history of poor mental health, overdose and/or self-harm, in circumstances where you had not assured yourself that it had been prescribed in accordance with the relevant guidance from the GMC, RPS and GPhC, in that it was prescribed in circumstances where the Prescriber had:

18.1. failed to verify the patients age;

209. The Committee has already satisfied itself that the Registrant was the regular RP for UK Meds on 17 December 2018 who had a duty to ensure the safe and effective running of the pharmacy.

210. It has had sight of a prescription dated 17 December 2018 of 84 tablets of ibuprofen 600mg issued to patient 5.

211. The Committee has considered the GPhC's guidance for registered pharmacies providing pharmacy services at a distance, including on the internet (January 2018) which states that to meet the standards under Principle 4: The way in which pharmacy services, including the management of medicines and medical devices, are delivered safeguards the health, safety and wellbeing of patients and the public, the pharmacy is expected to make sure *"you should be able to show the steps you have taken to minimise the risks you identify. This should include how you...make sure your pharmacy staff can...check that the patient is who they claim to be; and get all the information they need from patients to check that the supply is safe and appropriate, taking into account, for example, their age, gender, other medicines and other relevant issues".*

212. The Registrant said by way of an email from his solicitors on 13 October 2020 that he had "*no clinical reason to query a prescription for 84 x ibuprofen 600mg tablets. I was aware that the strength and dose on this prescription was within the standard*

therapeutic dose range of up to 1800mg daily in divided doses for adults and children over 12 years old. I was also aware that, as part of the website's registration process, service users were required to demonstrate that they were 18 years or older and that this requirement was expressly stated in the website's terms and conditions to which each service user agreed to be bound at the point of registration. It was also my understanding at the time that the prescribers reviewed patients' identity verification checks as part of their appropriateness and diligence check prior to issuing a prescription".

213. The Committee saw evidence that supported this; that there were checks made by Experian at the time which would have been fed through to the prescriber which verified the patient's name, address and details but may have had limitations in terms of verifying date of birth. It seems, from what the Committee has seen, and bearing in mind what patient 5 appears to have told her father, which was that "*all I had to do was tick a box to say I was over 18",* she gave a false date of birth in any event.

214. The Committee considers, overall, that for the Registrant who was dispensing or overseeing the dispensing, it would be unreasonable for him to have further assured himself that the prescriber had not failed to verify the patient's age when this was a situation where the patient had likely given a false date of birth, which had gone through a third party check and from the Registrant's point of view, would have been presented to him as someone who was indeed 18 years old. The Committee is not satisfied that there would have been sufficient red flags for the Registrant in his role as RP to question this.

215. It should be noted, finally, that the Council made an application to submit further evidence in respect of this charge which the Committee had sight of (a SOP from 2017) after it had closed its case. The Committee considered rule 24(9) which states that it may only allow a party to adduce written evidence at a hearing which has not been served in accordance with these Rules....in such exceptional circumstances as it may determine. However, having considered this evidence and the application by

the Council, the Committee neither thinks that this new evidence takes matters any further in respect of this particular, nor that there are sufficiently exceptional circumstances to admit it. Therefore, this evidence has not been admitted.

Particular 18.1 is therefore not proved.

18.2. failed to consider that the patient had already made one or more previous orders from UK Meds;

216. The Committee has considered its previous findings in respect of particulars 16.1 and 17.1 in which it found that it was unreasonable to expect the Registrant as RP to have assured himself that the medication had been prescribed in circumstances where the Prescriber had failed to consider that the patient had already made one or more previous orders from UK Meds because this was not something that the RP would have necessarily had knowledge of as he only would have had sight of the previous orders that had been dispensed by UK Meds. It adopts the same reasoning here for similar reasons.

217. It noted again that the Registrant said specifically in relation to this patient via his solicitors that "*[a]t the time of dispensing (17.12.2018) the pharmacy's checking dashboard did not display details of orders that had previously been placed by the website or the patient's answers to the current (or any previous) clinical questionnaire and so I only had sight of the prescription that had been approved and issued by the prescriber* ***together with the information that was contained in the pharmacy's patient medication record (PMR) which showed details of items that the pharmacy had previously dispensed to the patient***".(Our emphasis)

218. The PMR for patient 5 only shows one previous order for orlistat (a different category of drug) on 15 November 2018 and the evidence does not show whether this prescription was dispensed by UK Meds or another pharmacy and a previous

order for ibuprofen on 16 December 2018 which was refused and therefore would not necessarily have shown up on the records available to the RP.

219. It therefore does not consider it appropriate to find that the Registrant as RP on this date, was overseeing or dispensing in circumstances where he had not assured himself that it had been prescribed in circumstances where the prescriber had failed to consider that the patient had already made one or more previous orders from UK Meds.

Particular 18.2 is therefore not proved.

18.3. failed to obtain adequate information in relation to the patient's health in advance of prescribing;
18.4. relied principally on the information received in a patient completed online questionnaire;
18.5. failed to access and/or attempt to access the patient's 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/ misuse history;
18.6. failed to request a face-to-face or virtual consultation with the patient;
18.7. failed to adequately consider the possibility of medication dependence and/or misuse;

220. The Committee considered the statement of patient 5's father which confirmed that patient 5 had a history of anorexia, overdoses, depressive episodes and suicidal ideation. It has also seen the prescription request by patient 5 from 16 December 2018 (refused) and 17 December 2018 (issued). This shows a series of questions asked to the patient before the prescription was authorised. The Committee has taken into account the fact that during this time, prescribers were relying principally on the information received in the patient online questionnaire like this, and that in light of this, it is unlikely that adequate information was obtained in relation to the patient's health before prescribing, pursuant to the standards set out by GC about safe prescribing practice. Indeed, had adequate information been requested and/or

considered by the prescriber, and had there been any attempt to contact the patient's GP, the Committee considers it unlikely that 84 tablets of ibuprofen would have been prescribed for this patient. It notes that on the questionnaire, patient 5 selected the option to say she did not want UK Meds to contact their GP but considers this should have been a red flag for the prescriber. It goes without saying that in light of the Committee's findings that the prescriber on this day failed to obtain adequate information, that they also failed to adequately consider the possibility of medication dependence and/or misuse for this patient. This was clearly something that was an issue for patient 5, given her history and previous suicide attempt using medication.

221. Furthermore, the Committee is satisfied that the UK Meds model at that time was that information was principally being relied upon from a self-completed questionnaire and that there was no facility within this model to allow for a face to face consultation at this time. The practice was clearly that prescribers were relying principally on these questionnaires and the Registrant was well aware of this. He therefore should have only dispensed or overseen the dispensing on that day if he had been able to assure himself that it had been prescribed in accordance with the relevant guidance from the GMC, RPS and GPhC, which it had not.

Particulars 18.3, 18.4, 18.5, 18.6 and 18.7 are found proved.

18.8. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring; and/or
18.9. failed to put adequate safety-netting in place.

222. The Committee considers that in light of the number of ibuprofen tablets prescribed to patient 5 and her history, adequate safety netting and a referral back to her GP for appropriate assessment, review and monitoring should have taken place.

223. The Committee has considered the evidence relating to patient 5 carefully because the witness statement from her father is multiple hearsay and it has also borne in

mind that patient 5 may have had a reason to stretch the truth slightly so that she was not in trouble with her father. It noted however that there was no suggestion from patient 5 or her father that she was ever referred back to her GP or that adequate safety-netting was put in place; rather it seemed to be a simple procedure of her entering her order and a false date of birth and the prescription was issued.

224. In light of what the Committee has seen about the UK Meds model at this time, which did not seem to even have the facility to have adequate safety netting in place, and there being no evidence to suggest that patient 5 was referred back to her GP for appropriate assessment (or indeed any contact with patient 5's GP), it considers it more likely than not that there were these failures and that the Registrant as the regular RP at that time should have only dispensed or oversaw the dispensing on that day if he had been able to assure himself that it had been prescribed in accordance with the relevant guidance from the GMC, RPS and GPhC, which it had not.

Particulars 18.8 and 18.9 are therefore proved.

Particular 19

19. In relation to paragraph 2.2 above, on 11 January 2019, 29 January 2019 and 18 March 2019, you dispensed and/or oversaw the dispensing of 100 tablets of dihydrocodeine 30mg to Patient 10, a patient with a history of poor mental health and/or opioid overuse, in circumstances where you had not assured yourself that it had been prescribed in accordance with the relevant guidance from the GMC, RPS and GPhC, in that it was prescribed in circumstances where the Prescriber had:

19.1. failed to consider that the patient had already made one or more previous orders from UK Meds;

225. The Committee has considered its findings in respect of particular 2.2 which found that on 11 January, 29 January and 18 March 2019, the Registrant was the regular RP for UK Meds.

226. The Committee has seen the prescribing records from UK Meds in respect of patient 10 which show that she put in orders for dihydrocodeine on 10 January 2019 (15:48), 28 January 2019 (19:22) and 17 March 2019 (23:38) which were issued on the following days by the prescriber, so on 11 January 2019, 29 January 2019 and 18 March 2019 respectively. The dispensing on these dates was for 100 tablets of dihydrocodeine 30mg each time.

227. The Committee considered a letter from Greater Manchester Mental Health NHS Foundation Trust dated 29 May 2019 which the Committee considered as part of the Council's hearsay application. This stated that patient 10 had a long-standing history of anxiety and depression and was under the care of a private psychiatrist. This letter says that patient 10 "*stated that she is addicted to hydrocodeine and takes 10/20 tablets a day".* The Committee noted that this evidence certainly indicated that the patient had a history of poor mental health albeit it noted that the evidence in respect of opioid overuse post-dates the prescriptions issued by UK Meds so in theory this overuse could have developed after January – March 2019 when the prescriptions were issued.

228. In respect of the previous orders made by patient 10, the Committee can see that there were 4 previous orders made by patient 10 which were dispensed by UK Meds (as opposed to being outsourced to another pharmacy) before the first order on 10 January 2019 – orders for dihydrocodeine were made on 7 November 2018, 30 August 2018, 25 June 2018 and 25 April 2018.

229. It also reminded itself that the Registrant said via his solicitors that "*[a]t the time of dispensing (17.12.2018) the pharmacy's checking dashboard did not display details of orders that had previously been placed by the website or the patient's answers to the current (or any previous) clinical questionnaire and so I only had sight of the prescription that had been approved and issued by the prescriber* ***together with the information that was contained in the pharmacy's patient medication record (PMR) which showed details of items that the pharmacy had previously dispensed***

to the patient".(Our emphasis) Whilst this was the Registrant's account as to what he could see in December 2018, the Committee considers this was sufficiently close in time to these orders made by patient 10 and there is no indication that this model had changed by January 2019.

230. As stated, the PMR for this patient shows that there were 4 previous orders for dihydrocodeine by this patient, 6 previous orders by the time of the prescription dispensed on 18 March 2019.

231. The Committee also notes that the GPhC specifically asked the Registrant via his solicitors on 8 February 2021 *'Can you please confirm what steps the RP would be expected to take if they had any concerns about the prescription issued by a prescriber in the period April 2018- May 2019'.* The Registrants response via his solicitors was *"[o]ur client confirms that during the relevant period, if an RP had any concerns about any prescription issued by a prescriber, the RP would be expected to contact the relevant prescriber to address such concerns".*

232. The Committee therefore considers that the Registrant, as the regular RP dispensing or overseeing the dispensing of dihydrocodeine for patient 10, should have assured himself that it was being prescribed in accordance with the relevant guidance from the GMC, RPS and GPhC in that it was likely being prescribed in circumstances where the prescriber had failed to consider that the patient had already made one or more previous orders from UK Meds. Whilst the Committee accepts that the Registrant will not have necessarily had knowledge as to what the prescriber had considered when prescribing, it feels there is a strong inference that he or she had not given due consideration to these previous orders which should have raised a red flag to the Registrant who would also have been able to see these from the dispensing PMR. It therefore considers it more likely than not that the Registrant should have been alerted that the prescriber had failed to consider these previous orders which was not in accordance with the relevant guidance.

Particular 19.1 is therefore found proved.

19.2. failed to obtain adequate information in relation to the patient's health in advance of prescribing;
19.3. relied principally on the information received in a patient completed online questionnaire;
19.4. failed to access and/or attempt to access the patient's 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/misuse history;
19.5. failed to request a face-to-face or virtual consultation with the patient;
19.6. failed to adequately consider the possibility of medication dependence and/or misuse;
19.7. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring; and/or
19.8. failed to put adequate safety-netting in place.

233. The Committee considered the report from a consultant psychiatrist at Timperley Health Centre in respect of patient 10 dated 13 November 2018 which confirmed that patient 10 had a history of borderline personality disorder, chronic dysthymia and social anxiety disorder and had been under the care of the Priory Hospital with some evidence of self-harm.

234. The Committee also considered a request from the GPhC to UK Meds asking for the PMR for patient 10 and in particular, "*[e]vidence of all communication with the patient and the patient's GP"*. The response from UK Meds to this was "*[n]o such item exists and/or none recorded".*

235. It has also noted the referral from a pharmacist on 5 July 2019 who raised concerns about patient 10 after an emergency hospital admission on 20 May 2019 after the patient became "*increasingly dependent on dihydrocodeine*" and was now "*under treatment of the addiction centre".* This report said that the patient was *"able to use google search terms 'buy dihydrocodeine online' and be directed to a website allowing the direct selection of an opioid painkiller. They then can fill in a short*

questionnaire and be sent a large supply of medication which they are addicted to. The company do not inform the patient's regular GP and this supply can be made multiple times (more than 10)".

236. Whilst the Committee accepts that the majority of this evidence is hearsay and therefore needed to be treated with caution, it found it reliable in many respects as it could see no reason to doubt the authenticity and credibility of such reports. For example, the psychiatric reports which would have been compiled in the course of the professional's duties.

237. The Committee considers that all this evidence suggests that it is more likely than not that the prescribing decisions on 11 January, 29 January and 18 March 2019 happened in circumstances where the prescriber failed to obtain adequate information about the patient's health in advance of prescribing and failed to access or attempt to access the patient's GP records in order to have a full picture of their physical or mental health. Indeed, had this information been requested and/or considered by the prescriber, the Committee considers it unlikely that dihydrocodeine would have been prescribed for this patient in these circumstances, or certainly not without further follow up with the patient's GP or safety netting. There was no evidence of this occurring. This was someone who had had numerous previous orders for large quantities of dihydrocodeine at regular intervals and a large number of tablets were being prescribed without any evidence of the patient being referred for further assessment or follow up with their GP. This was also a patient who had the clear potential to misuse this medication and become dependent, as indeed the evidence suggested she did. There is no evidence to suggest this was considered by the prescribers when they made these prescribing decisions.

238. Furthermore, the Committee is satisfied that the UK Meds model at that time was that information was principally being relied upon from a self-completed questionnaire and that there was no facility within this model to allow for a face to face consultation at this time. The practice was clearly that prescribers were relying

principally on these questionnaires and the Registrant was well aware of this. He therefore should have only dispensed or overseen the dispensing on these days if he had been able to assure himself that the medicines had been prescribed in accordance with the relevant guidance from the GMC, RPS and GPhC, which they clearly had not.

Particulars 19.2, 19.3, 19.4, 19.5, 19.6, 19.7 and 19.8 are therefore found proved.

Particular 20

20. In relation to paragraph 2.2 above, on 10 December 2018 , you dispensed and/or oversaw the dispensing of 100 tablets of dihydrocodeine 30mg to Patient 16, a patient with a history of poor mental health, overdose and/or self-harm, in circumstances where you had not assured yourself that it had been prescribed in accordance with the relevant guidance from the GMC, RPS and GPhC, in that it was prescribed in circumstances where the Prescriber had:

20.1. failed to consider that the patient had already made one or more previous orders from UK Meds;

239. The Committee has considered the evidence in respect of this charge, namely the PMR for patient 16 and noted that the medicine which was dispensed on 10 December 2018 was not, as stated in the allegation "100 tablets of dihydrocodeine 30mg", rather it was amitriptyline.

240. The Committee has considered its powers under rule 41 which says that *"at any stage before making its findings of fact, the Committee may of its own motion...amend the particulars of the allegation set out in the Notice of Hearing, unless it is of the view that the required amendment would prejudice the fairness of the proceedings. Before making any amendment...the Committee must consider (a) any representations from the parties (where present)...".*

241. It has therefore asked for any representations from the case presenter, Mr Hoskins about this clear error in the charge.

242. Mr Hoskins said that the amendment should be allowed because it was clearly a typographical error and that the amendment better reflected the evidence that had been served on the Registrant previously, including the description of it that was included in the Council's opening note and served on the Registrant. He further submitted that this was not something that the Registrant had raised as an issue at any point in his exhibit 6 submissions.

243. The Committee has carefully considered these submissions and the fact that this would be a late amendment to the particulars of this allegation. It has not reached its findings of fact in respect of this charge and so considers it can, of its own motion, amend it if it considers that such an amendment would not prejudice the fairness of the proceedings.

244. In considering this, the Committee has reminded itself that fairness involves fairness to both the Registrant and the Council. For the Registrant, the Committee recognises that a late amendment to the charge he faces could be prejudicial. However, it also notes that the Registrant has chosen not to attend these proceedings and that the change of the medicine type reflects the true nature of the evidence as it has always been presented by the Council.

245. The Committee has also reminded itself that there is a real patient behind this charge who is alleged to have suffered harm as a result of her interaction with UK Meds. In that respect, the Committee has reminded itself of section 6 of the Pharmacy Order 2010 which states that:

"The main objective of the Council (including its staff and committees) in exercising such of its functions as affect the health, safety or well-being of members of the public is to protect, promote and maintain the health, safety and well-being of members of the public, and in particular of those members of the public who use or need the services of registrants, or the

services provided at a registered pharmacy, by ensuring that registrants, and those persons carrying on a retail pharmacy business at a registered pharmacy, adhere to such standards as the Council considers necessary for the safe and effective practice of pharmacy."

246. The Committee therefore considers that it is right and proper to make this amendment from 'dihydrocodeine' to '56 tablets of amitriptyline 25mg' and that it does not consider this would prejudice the fairness of the proceedings.

247. The Committee has therefore gone onto consider its finding on the facts in respect of allegation 20.
20.1. failed to consider that the patient had already made one or more previous orders from UK Meds;

248. The Committee has already noted that on 10 December 2018, the PMR and prescription itself shows that 56 tablets of amitriptyline 25mg was dispensed to patient 16.

249. The Committee has seen a vast amount of information about patient 16's mental health which shows that she had a history of poor mental health, overdose and self-harm. In particular, it notes a discharge summary from Cheshire and Wirral Partnership NHS Foundation Trust dated 20 April 2017 which states that patient 16 was "*well known to CAMHS services"* and had made "*multiple attempts at ligatures*" and had been diagnosed with an emotionally unstable personality disorder. Whilst the Committee notes that there are some odd redactions within this document, there appears to be a clear reference to previous self-harm by this patient, including a previous overdose of sertraline and amitriptyline.

250. The Committee has considered its previous findings in respect of particulars 16.1, 17.1 and 18.2 in which it found that it was unreasonable to expect the Registrant as RP to have assured himself that the medication had been prescribed in circumstances where the Prescriber had failed to consider that the patient had already made one or more previous orders from UK Meds because this was not

something that the RP would have necessarily had knowledge of as he only would have had sight of the previous orders that had been dispensed by UK Meds. It adopts the same reasoning here for similar reasons.

251. The PMR for patient 16 shows three previous orders on 6 April 2017, 18 February 2017 and 6 November 2016 but these prescriptions were dispensed by a different pharmacy (Innox pharmacy) and therefore would not necessarily have shown up on the records available to the RP when dispensing or overseeing dispensing on 10 December 2018.

Particular 20.1 is therefore not proved.

20.2. failed to obtain adequate information in relation to the patient's health in advance of prescribing;
20.3. relied principally on the information received in a patient completed online questionnaire;
20.4. failed to access and/or attempt to access the patient's 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/ misuse history;
20.5. failed to request a face-to-face or virtual consultation with the patient;
20.6. failed to adequately consider the possibility of medication dependence and/or misuse;
20.7. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring; and/or
20.8. failed to put adequate safety-netting in place.

252. The Committee considered the vast amount of medical evidence in respect of this patient's medical history, including the discharge summary already referenced in its findings that showed patient 16 had a significant history of poor mental health and notably, had taken an overdose previously of amitriptyline.

253. The Committee also considered a request from the GPhC to UK Meds asking various questions about the prescriptions for patient 16 and in particular, *"was consent to contact the GP given by the patient? If so, was GP contact made prior to approving the prescription?"* to which UK Meds responded: "*No consent provided by the patient in any order"*. Further, of note is the following question which asked for *"[d]etails about the review of the request carried out by the prescriber"* to which UK Meds responded: *"They reviewed the questions and then made a decision to prescribe. No additional notes added to the patient's PMR".* When asked *"what, if any contact was there between the prescriber and the patient?"* the response from UK Meds was *"None recorded".* When asked *"What, if any contact was there between the prescriber and/or the pharmacy and the patient's own GP or others involved in [patient 16's] care?"* the response was *"None recorded"*.

254. The Committee considers that this evidence shows that it is more likely than not that the prescribing decision on 10 December 2018 happened in circumstances where the prescriber failed to obtain adequate information about the patient's health in advance of prescribing and failed to access or attempt to access the patient's GP records in order to have a full picture of their physical or mental health. Indeed, had this information been requested and/or considered by the prescriber, the Committee considers it unlikely that amitriptyline would have been prescribed for this patient in these circumstances, or certainly not without further follow up with the patient's GP or safety netting. There was no evidence of this occurring which accords with UK Meds' own admission. This was a patient who had the clear potential to misuse this medication and self-harm with it, as indeed the evidence suggested she did. There is no evidence to suggest this was considered by the prescribers when they made these prescribing decisions.

255. Furthermore, the Committee is satisfied that the UK Meds model at that time was that information was principally being relied upon from a self-completed questionnaire and that there was no facility within this model to allow for a face-to-face consultation at this time. Indeed, the answers that UK Meds provided as referenced above seem to accept there was no attempt to contact the patient or do

anything other than prescribe based on the questionnaire filled in. There was no evidence of an attempt to refer patient 16 back to her GP or put any safety-netting in place for her. The Registrant therefore should have only dispensed or overseen the dispensing on this day if he had been able to assure himself that the medicine had been prescribed in accordance with the relevant guidance from the GMC, RPS and GPhC, which it clearly had not.

Particulars 20.2, 20.3, 20.4, 20.5, 20.6, 20.7 and 20.8 are therefore proved.

21. In relation to paragraph 4 your approach to prescribing and/or dispensing in any or all of paragraphs 5 to 20 above was transactional in that you and/or your staff processed patient requests by reference to a patient completed online questionnaire rather than in accordance with UK prescribing guidance.

256. The Committee has considered the meaning of the word 'transactional' and the way in which the Council has put this allegation which is that UK Meds were processing patient requests by reference to a patient completed online questionnaire rather than in accordance with UK prescribing guidance.

257. The Committee has reminded itself about the relevant prescribing guidance at this time, which said that when prescribing, a prescriber should assess the patient, consider the options, reach a shared decision and then prescribe a medicine *"only with adequate, up-to-date awareness of its actions, indications, dose, contraindications, interactions, cautions and unwanted effects"* (RPS Competency Framework 2016) and in a safe and effective way. The Committee has also reminded itself again of GC's evidence which stated the importance, amongst other things, of the prescriber conducting an appropriate clinical assessment, a risk assessment, a therapeutic consultation involving face to face interaction with the patient and adequate safety netting.

258. The Committee has carefully considered all of this evidence even though it does not summarise it all here.

259. In light of the findings that the Committee has made in particulars 5 – 20, which it does not intend to repeat here, it accepts that the approach to prescribing and/or dispensing by the Registrant during his time as SI and RP at UK Meds could indeed be described as 'transactional' for all the reasons given within those particulars.

Particular 21 is therefore proved.

22. In relation to paragraphs 1 and/or 3 above, you entered into business agreements with third-party online pharmacies to dispense medicines in circumstances where the UK Meds' prescribing model or service was incapable of supporting safe prescribing decision(s) in that:

22.1. patients provided information primarily through an online questionnaire;

22.2. no face-to-face or other virtual consultation took place; and/or

22.3. UK Meds was not registered with an appropriate UK regulator.

260. The Committee has seen evidence in the form of a questionnaire sent by the GPhC to UK Meds asking it to provide details for the third-party pharmacies which supplied medicines for UK Meds. These were provided by way of a list of pharmacies that UK Meds used "*for the dispensing of private prescriptions issued by registered prescribers after a consultation with the patient*": Medimex, Your Local, Littleover, Tower, Homecare, Applegate, Avviro, Fusion and Innox. This questionnaire asked, '*who at the third-party pharmacies carried out due diligence, communicated/negotiated the agreement with UK Meds?*' and the response from UK Meds was that this was JS and MS. The Committee understands this to mean that, in fact, the names from UK Meds side were JS and MS rather than the third-party side. These are the names who are said to have negotiated the business agreement between UK Meds and these third-party pharmacies.

261. There is no evidence to suggest that the Registrant entered into any business agreements with these third-party pharmacies, certainly not in his role as SI between 11 October 2018 and 6 September 2021 or even as director between 4 May 2020 and 13 October 2021.

Particular 22 in its entirety is therefore not proved.

23. Between June 2021 and 13 October 2021, UK Meds facilitated access and/or signposted patients to EU Meds Direct Limited ("EU Meds"), a prescribing service based in Dubai, in circumstances where EU Meds' prescribing model or service was incapable of supporting safe prescribing;

24. In relation to paragraphs 22 and/or 23 above, you oversaw deliberate attempts to circumvent the GPhC's conditions that prevented UK Meds' sale or supply of Schedule 1-5 Controlled Drugs, modafinil and amitriptyline, in that:

24.1. UK Meds' website provided a link signposting patients to EU Meds; and/or

24.2. EU Meds was outside a UK regulator's jurisdiction.

262. The Committee considered the evidence of RC who detailed concerns raised in an enforcement action meeting on 24 June 2021 that there were links on UK Meds website which took patients to another organisation called EU Meds Ltd. There were also text messages going to existing patients signposting them to EU Meds in order to purchase medicines such as codeine.

263. On 30 July 2021, a third notice of conditions was served on UK Meds by RC which stated that UK Meds "*must not signpost or facilitate the direction of people to third party prescribing services that are not registered with a UK regulator. This includes, but is not limited to, through links on the pharmacy's own website, advertising, direct marketing or any form of 'social media'*".

264. On 13 August 2021, the Registrant received an email from RC stating that "*we have observed that for new customers your UK Meds Direct Ltd site now blocks the link to EU Meds. However, we have also observed that if a customer has historically followed the link then it is still functional. Please can you take action to deactivate the link in all circumstances".*

265. The Committee noted that the Registrant's explanation for this was that a customer who had already visited an external site, such as EU Meds, would be redirected to that site by their own browser when visiting the UK Meds website, even though the redirect was inactive but that any new customers would not be redirected in this way. He said that he did not engage or direct any activity that was encouraging and signposting patients to EU Meds; rather "*he advises that he fully complied with the terms of the conditions imposed on UK Meds Direct Ltd on 30 July 2021 until the time of his resignation as superintendent pharmacist".*

266. Further, the Registrant said in his exhibit 6 that *"My understanding is that certain website backlink arrangements had been implemented at the ownership level without my knowledge or involvement in their creation. Once identified to me, those links were removed promptly".*

267. The Committee considered all this evidence carefully, including the Registrant's explanations above, which it has no reason to doubt. It noted in particular that Mr RC was asked in evidence whether there was any evidence that the Registrant would have been aware of this link prior to Mr RC informing him of such. Mr RC said that he had no idea whether the Registrant would have known. There is certainly no evidence to suggest that there were any deliberate attempts by the Registrant to circumvent the GPhC's conditions.

268. The Committee therefore does not consider there to be sufficient evidence to establish that the Registrant had facilitated access or signposted patients to EU Meds. Whilst it accepts there may be some evidence to suggest that UK Meds as a body corporate was facilitating access to the same, it does not have any evidence about the EU Meds model to suggest that this website was incapable of safe prescribing in any event.

269. In light of its findings in respect of particulars 22 and 23 above, there is no basis on which the Committee can find particular 24 proved.

Particulars 23 and 24 are therefore not proved

Misconduct and Impairment

270. Having found the facts proved in particulars 1, 2, 3, 4, 5, 6, 7, 8, 10.1, 10.2, 10.3, 10.5, 11, 12.1-12.5, 13, 14, 15, 16.2-16.8, 17.2-17.8, 18.3-18.9, 19, 20.2-20.8 and 21, the Committee went on to consider whether the particulars found proved amounted to misconduct and if so, whether the Registrant's fitness to practice is currently impaired.

271. In doing so, the Committee took account of Article 51(1) of the Pharmacy Order 2010 which provides that:

"A person's fitness to practice is to be regarded as "impaired" for the purposes of this Order only by reason of – (a) misconduct…"

272. It also took into account the GPhC's Good decision making: Fitness to practise hearings and outcomes guidance (revised March 2024) ("the Guidance") which states at paragraph 2.12 that:

"A pharmacy professional is 'fit to practise' when they have the skills, knowledge, character, behaviour and health needed to work as a pharmacist…safely and effectively. In practical terms, this means maintaining appropriate standards of competence, demonstrating good character, and also keeping to the principles of good practice set out in our various standards, guidance and advice."

273. The Committee followed the approach outlined in the judgment given by Mr Justice Cranston at paragraph 19 in *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."

274. The Committee took into account the submissions made by Mr Hoskins, on behalf of the Council and those made by Mr Morjaria. It took into account the advice from the legal assessor.

GPhC submissions on misconduct and impairment

275. Mr Hoskins, on behalf of the Council submitted that the conduct found proved constituted clear misconduct which should properly be regarded as current impairment on both public protection and public interest grounds.

276. He relied on a number of authorities to support this proposition, namely:

- *Cheatle v GMC [2009] EWHC 645 (Admin)*
- *Roylance v General Medical Council (No.2)*[2000] 1 A.C. 311
- *Meadow v General Medical Council [2007] 1 All ER 1*
- *Remedy UK Ltd v General Medical Council* [2010] EWHC 1245 (Admin)
- *Shaw v General Osteopathic Council [2015] EWHC 2721 (Admin)*
- *Spencer v General Osteopathic Council [2012] EWHC 3147*
- *Wingate v. SRA* [2018] EWCA Civ 366,
- *Cohen v General Medical Council* [2008] EWHC 581 (Admin)
- *Yeong v General Medical Council* [2009] EWHC 1923 (Admin)
- *CHRE v NMC and Grant* EWHC 927 (Admin)

277. Mr Hoskins submitted that the Registrant had breached the Standards of Pharmacy Professionals (May 2017) ("the Standards") in respect of:

- Standard 1: provide person-centred care
- Standard 2: work in partnership with others
- Standard 3: communicate effectively
- Standard 4: maintain, develop and use professional knowledge and skills
- Standard 5: use professional judgement
- Standard 6: behave in a professional manner
- Standard 8: speak up when they have concerns or when things go wrong
- Standard 9: demonstrate leadership

278. Mr Hoskins submitted that the extent of falling short was evidently significant so as to properly be regarded as at the most serious end of the scale of misconduct. He submitted that the systems and processes at UK Meds (for which the Registrant held significant responsibility) were shocking and dangerous which pointed to an attitudinal issue which was contrary to the very role as a pharmacist and a significant deviation from the cornerstone of a caring profession; instead demonstrative of self-interest. He submitted that this justifies a finding by the Committee of current impairment on both public interest and public protection grounds.

The Registrant's submissions on misconduct and impairment

279. Mr Morjaria submitted a written document titled "Written Submissions following the Committee's determination on the facts" on 27 July 2026.

280. He said he had developed insight throughout these proceedings and that the past several years have given him a great deal of time for reflection although "*aspects of the reasoning differ from the understanding that I held at that time".*

281. Mr Morjaria said that the greatest reflection from the Committee's analysis has been the role and responsibilities of the Superintendent Pharmacist ("SI").
He said that during the relevant period, he believed his responsibilities were discharged through *"establishing and strengthening appropriate governance arrangements, developing and reviewing Standard Operating Procedures, introducing technological safeguards, improving identity verification processes, responding to inspection findings and working collaboratively with colleagues to improve the systems through which pharmacy services were delivered".* He said he also understood that independently registered prescribers remained professionally responsible for the prescribing decisions they made. He says he now understands the distinction the Committee has drawn between implementing governance arrangements and obtaining sufficient assurance that those arrangements were consistently operating effectively in practice which has become one of the central themes of his reflection.

282. Mr Morjaria said that the most difficult aspect of reading the determination on facts has been revisiting the individual patient cases that sit behind these findings. He says he recognises these were vulnerable individuals that deserve compassion and "*whose circumstances have remained with me throughout these proceedings"*. He said that during his time as SI, much of his work centred upon governance, operational oversight, systems development and professional leadership rather than individual prescribing decisions but that he now recognises that the purpose of these policies and procedures is to protect the people who rely upon healthcare professionals to keep them safe. He said he has sincere regret that patients experienced harm and that these lessons will remain with him.

283. Mr Morjaria further said that he was working within a rapidly developing area of healthcare at the time where decisions were not the responsibility of a single individual acting in isolation. He says he now recognises that "*there were occasions when I should have sought greater assurance regarding the effectiveness of governance arrangements rather than concentrating principally upon their continued development*".

284. He said that during his tenure, he made considerable effort to strengthen governance and introducing safeguards and that he has since learned that governance is a continuing process that requires constant evaluation, independent challenge and an unwavering focus on patient outcomes. He says he understands now that professional leadership carries more responsibilities and that behind every process is an individual patient.

285. There was no admittance of misconduct or current impairment.

Decision on misconduct

286. The Committee had regard to the submissions both from the Registrant and the Council. It reminded itself that there was no strict definition of misconduct but considered what Lord Clyde in *Roylance v General Medical Council* (No.2) [2000] 1 A.C. 311 at paragraph 35 stated:

"*Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed.....in the particular circumstances*."

287. The Committee considered whether the Registrant had breached any of the Standards that were in place at the time. The Committee determined that there has been a breach of the following Standards:

Standard 1 Pharmacy professionals must provide person-centred care

288. Mr Hoskins submitted that both in his role as SI and Responsible Pharmacist ("RP"), the Registrant breached this standard by failing to ensure there was communication between prescribers and patients or their GPs and instead worked via a system whereby medications were first prescribed and then dispensed on the basis of an online questionnaire which was the antithesis of person-centred care.

289. The Committee considers Standard 1 to be extremely important as it emphasises the need to make the care of the person the pharmacist's first priority. Pharmacy care should be a two-way collaborative process, whereby the pharmacist listens to the person and understands their needs and what matters to them and then considers the impact that their practice might have on them, whether or not they provide care directly to the patient. It involves ensuring the patient is involved, supported and enabled when making decisions about their health and that the patient remains informed at all times. The UK Meds model fundamentally failed to deliver patient-centred care, and the Registrant, as SI, bore responsibility for this. Patients were not adequately involved, supported or empowered to make informed decisions about their health, care and wellbeing. The reliance on questionnaires as the primary means of obtaining patient information significantly limited meaningful engagement with individual patients and hindered the delivery of person-centred care.

290. Prescribers did not routinely follow up with patients, nor was there sufficient consideration of the ongoing impact of prescribing decisions on patient outcomes. The Registrant operated within a highly process-driven model that prioritised efficiency over individualised patient care. As a result, patients did not receive the level of attention and engagement that their circumstances may have required, a foreseeable consequence of such a model. The volume and speed with which prescriptions were issued further heightened these concerns. The Committee therefore considered this to represent a clear and serious breach of the standard.

Standard 2 - Pharmacy professionals must work in partnership with others

291. Mr Hoskins submitted that there was a notable failure by the Registrant and others under his supervision and oversight to contact patient's GPs or care providers but also in failing to discharge the obligations of the improvement notices issued by the GPhC.

292. The Committee agrees that Standard 2 has been breached. Standard 2 says that a person's health, safety and wellbeing are dependent on pharmacy professionals working in partnership with others, where everyone contributes towards providing that person with the care they need. That clearly did not happen in this case. The Committee identified failings both in the Registrant's engagement with the GPhC and in his working relationship with the independent prescribers operating within the UK Meds model. Although information was ultimately provided to GPhC inspectors, there were delays in doing so which hindered the effectiveness and efficiency of the inspection process. The Committee was also concerned by the Registrant's limited oversight of the independent prescribers. It appeared that he regarded them as being solely responsible for their own practice, without recognising his obligation, as SI, to provide appropriate leadership, supervision and assurance. The Committee considered that the Registrant should have engaged more proactively with prescribers, monitored their practice more closely, and satisfied himself that appropriate safeguards were in place. Had he done so,

concerns regarding prescribing practices and patient safety may have been identified and addressed at an earlier stage.

293. There was clearly a wealth of data available to the Registrant which could have been used to monitor and evaluate the practice of the independent prescribers. However, the Committee saw little evidence that he sought to make effective use of this information to identify trends, assess prescribing practices, or address emerging risks. Whilst the Committee accepts that the Registrant took some steps to improve governance arrangements and work collaboratively with others, those efforts fell significantly short of what was required in the circumstances. As an experienced SI, he ought to have recognised the serious and systemic concerns that were developing within the service.

294. The Committee identified a number of fundamental shortcomings, including inadequate clinical records to support prescribing decisions, an absence of continuity of care, insufficient ongoing monitoring of patients, and limited communication with, or follow-up of, patients' GPs. The evidence before the Committee included a number of patient cases in which further review, monitoring, or liaison with other healthcare professionals was clearly warranted but did not occur, with significant consequences for those involved. Taken together, these failings demonstrated a clear breach of this standard.

Standard 3 - Pharmacy professionals must communicate effectively

295. Mr Hoskins submitted that the allegations found proved demonstrated a lack of communication between patients and prescribers in the systems and processes employed at UK Meds which the Registrant was charged with maintaining.

296. The Committee agrees with this. The Committee considered that the UK Meds model, which relied predominantly on patient-completed questionnaires, significantly limited the two-way communication that is fundamental to the delivery of safe and effective care. There was minimal direct engagement between patients and prescribers, reducing opportunities to explore relevant clinical issues, ask follow-

up questions, or gain a fuller understanding of a patient's individual circumstances and needs. The Committee was concerned that this model impeded meaningful dialogue and restricted the ability of prescribers, and the RP, to exercise proper clinical judgement.

297. The Committee also identified shortcomings in the safety-netting arrangements. Without adequate communication, prescribers were unable to satisfy themselves that patients understood the information and advice provided, the risks associated with treatment, or the steps they should take if their condition changed or they experienced adverse effects. The structure of the UK Meds model created barriers to such interactions and limited opportunities for ongoing clinical engagement, thereby undermining an important safeguard for patient safety.

298. Communicating with patients and professionals seemed to be the exception rather than the norm. UK Meds seemed to resist any changes to this model and when concerns were raised by the GPhC, they removed themselves from regulatory oversight rather than make changes. Even when GPs were contacted, they were often only given a day to respond. It seemed that the UK Meds model was more about commercial transactions and speed than patient care and communication. The Registrant was senior enough and in a position of responsibility that he should have been alive to this and helped facilitate change, but he did not do enough. The Committee therefore considers there has been a clear breach of this standard.

Standard 4 - Pharmacy professionals must maintain, develop and use their professional knowledge and skills

299. Mr Hoskins submitted that there was a lack of appreciation by the Registrant and prescribers as to the risks of Modafinil and Amitriptyline in respect of charges 11 and 12 which demonstrates a breach of this standard.

300. The Committee agrees that standard 4 has been breached. The Committee considered the Registrant's submissions regarding his understanding of the SI role during the relevant period and found them to be insufficient. In the Committee's

view, the Registrant did not fully appreciate the breadth of responsibility associated with such a senior position. His evidence suggested that he regarded governance primarily as the development and implementation of policies and procedures, without a corresponding understanding of the need to ensure that those arrangements were operating effectively in practice and delivering safe patient outcomes.

301. Whilst the Committee acknowledged the Registrant's submission that he was working within a rapidly evolving area of healthcare, it did not consider this to be an adequate explanation for the deficiencies identified. Pharmacy professionals are expected to maintain, develop and apply their knowledge and skills in response to changes in professional practice and the wider healthcare environment. The changing nature of online prescribing and remote healthcare increased, rather than diminished, the need for robust professional oversight. The Committee considered that the Registrant should have ensured that his knowledge and understanding evolved accordingly so that he could discharge his responsibilities as SI effectively and safeguard patients.

302. The Committee was particularly concerned that many patients using UK Meds were seeking high-risk medications outside of their usual healthcare arrangements, rather than through healthcare professionals with an established understanding of their medical history and ongoing clinical needs. In the Committee's view, this should have alerted the Registrant to the heightened risks inherent in the service and the need for increased vigilance and safeguards. However, there was little evidence that he fully appreciated the motivations of some patients seeking these medications, or the risks that such prescribing practices presented. The Committee considered this to be a significant oversight.

303. As SI, the Registrant was expected to maintain and develop his professional knowledge and apply it to the evolving challenges of online prescribing and remote healthcare. The Committee considered that he should have ensured that his

knowledge and understanding remained sufficiently up to date to identify these risks and implement appropriate safeguards for vulnerable patients. Whilst the Committee accepts that specific guidance relating to this area of practice was still developing and that further guidance emerged in 2019, the fundamental principles of safe and effective patient care, clinical risk management, and professional accountability were well established. The Committee considered that the Registrant ought to have understood and applied those principles throughout the relevant period.

304. The Committee finds this standard to have been breached.

Standard 5 - Pharmacy professionals must use their professional judgement skills

305. Mr Hoskins submitted that the Registrant's submissions at both stage 1 and 2 of these proceedings demonstrate a failure to appreciate or discharge the fundamental obligations as an SI and use his professional judgement to ensure that patient care was secured.

306. The Committee found that this standard has been breached. As previously noted, there were clear failings in the Registrant's ability to make patient welfare his primary concern and to act consistently in patients' best interests. The Committee found that, in practice, the Registrant appeared to prioritise the interests of UK Meds over those of the patients using its services. The business model was centred on speed, volume and operational efficiency, considerations which frequently sat in tension with the delivery of safe, individualised patient care. The Committee considered that insufficient regard was given to the particular needs, circumstances and vulnerabilities of individual patients, with the result that patient care was secondary to a process-driven and commercially focused approach.

307. As a director of UK Meds from 2020 onwards, the Registrant occupied a position of significant influence and responsibility. The Committee considered that he should have been a strong advocate at board level for the maintenance of professional pharmacy standards and the delivery of safe and effective patient care, using his position to challenge practices that gave rise to patient safety concerns. However, in

his submissions, the Registrant appears to distance himself from board decisions and to minimise the extent of his influence within the organisation. The Committee did not find that position persuasive, given the seniority of the roles he held.

308. The Committee was also concerned by the apparent conflict between the commercial priorities of the business and the Registrant's professional obligations as a pharmacist. Whilst the Committee accepts that the Registrant was not a shareholder and did not have a direct financial interest in the company, he nevertheless chose to accept and remain in a senior leadership position within an organisation whose operating model prioritised high-volume prescribing and operational efficiency. In the Committee's view, those priorities did not sit easily with the delivery of safe, patient-centred care. The Registrant should have recognised and addressed that conflict, rather than focus on the business.

309. This standard has been breached in clear terms.

Standard 6 – Pharmacy professionals must behave in a professional manner.

310. Mr Hoskins submitted that the Registrant had failed to act with integrity and that this was evidenced by the findings in respect of charge 21, which found the approach to prescribing and/or dispensing to be transactional.

311. The Committee agrees that Standard 6 has been breached and that the Registrant acted in a manner that calls his integrity into question. Whilst the Committee accepts that there is no allegation of dishonesty against the Registrant, and that the evidence demonstrated that he engaged with GPhC inspectors in a polite and courteous manner throughout, it nevertheless has concerns regarding his priorities in relation to the UK Meds business model and the senior positions that he held within the organisation.

312. The Committee considers that the fundamental purpose of the pharmacy profession is to safeguard patients and to deliver safe and effective care. In this case, those professional obligations were undermined by the commercial priorities and

operational objectives of the UK Meds model. As SI, the Registrant should have ensured that patient welfare remained the paramount consideration. Whilst the Committee recognises that there is nothing inherently improper about operating a pharmacy as a commercial enterprise or generating profit, commercial considerations must never take precedence over patient safety and professional standards.

313. The Committee found that the focus of both the UK Meds model and the Registrant's approach as SI was directed more towards commercial activity and high-volume prescribing than towards the delivery of patient-centred care. In the Committee's view, the Registrant failed to ensure that professional obligations and patient welfare remained at the forefront of decision-making. That failure, particularly in light of his senior leadership role, raises serious concerns regarding his professional integrity and amounts to a clear breach of this standard.

Standard 8 – Pharmacy professionals must speak up when they have concerns or when things go wrong

314. Mr Hoskins submitted that whilst the Registrant interactions with the GPhC were appropriate and courteous, his attitude was far from proactive in terms of raising issues and problems that were evidently severe enough to undermine patient safety. Instead, he submitted his responses were reactive, waiting for significant failings to be pointed out when they must have been self-evident.

315. The Committee agrees with this. As set out in the standard, the quality of care that people receive is improved when pharmacy professional learn from feedback and incidents and challenge poor practice and behaviours. As a senior leader within UK Meds and a registered pharmacist, the Registrant should have been the individual who identified, challenged and escalated concerns regarding patient safety and professional practice.

316. However, the evidence showed that the Registrant did not challenge poor practice or behaviour. He did not question the prescribers when he should have. He did not recognise the safety concerns and act upon them. Even if the Registrant did not feel able to raise concerns directly with the GPhC, the Committee considered that he should, at the very least, have challenged matters internally. Given his seniority within the organisation and his responsibilities as a registered pharmacist, he should have questioned directors and colleagues about the risks that had been identified, sought assurance that appropriate audits were being undertaken, and satisfied himself that effective measures were in place to mitigate patient safety concerns. The Committee found little evidence that he took such proactive steps.

317. Even when concerns were identified by the GPhC, there was a failure and a lack of urgency to change these practices and make things right. Whilst the Committee appreciates that the Registrant says he did not know about the links to the EU Meds website and that when he did find out the links were disabled quickly, it remains concerned that he says he did not know. He should have known. As SI and later, director of UK Meds, he should have made it his business to know. He was too reactive in his role and not proactive. The fact that he did not speak up or challenge poor practice makes him complicit in it.

Standard 9 - Pharmacy professionals must demonstrate leadership

318. Mr Hoskins submitted that the role of SI was a significant leadership role which the Registrant accepts in his submissions.

319. The Committee considers there was a clear breach of this standard. As an SI and later director of UK Meds, the Registrant should have been taking responsibility for his actions and leading by example. The Standards say a pharmacy professional must do everything they can to keep the risks in the care they provide as low as possible. This was not done. The Committee considered that the Registrant failed to demonstrate the leadership expected of a Superintendent Pharmacist. Rather than challenging practices that gave rise to patient safety concerns, he appeared to accept the prevailing approach within the organisation. His position that

independent prescribers were responsible for their own prescribing decisions reflected a failure to recognise his responsibility to provide appropriate leadership, oversight and assurance. The Committee therefore considered that this standard had been clearly breached.

320. The Committee has considered whether this breach of the Standards amounts to misconduct and it finds that it does. It has asked itself whether the misconduct is serious professional misconduct with reference to these standards and the published guidance by the Council. It has reminded itself that not all breaches of the standards will necessarily amount to serious professional misconduct.

321. It has considered the case of *Remedy UK v. GMC* (2010) EWHC 1245 in which Elias LJ said:

"misconduct is of two principal kinds. First it may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to FTP. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur out with the course of professional practice itself, but which brings disgrace upon the [R] and thereby prejudices the reputation of the profession".

322. The Committee finds that this is misconduct in the first limb, namely within the exercise of professional practice that goes directly to the Registrant's fitness to practice. It finds the misconduct to be serious and deplorable. There were real and often vulnerable individuals affected by both the Registrant's conduct and the way in which UK Meds operated during his tenure as Superintendent Pharmacist and Responsible Pharmacist. Whilst the Committee accepts that the harm suffered by those patients was not directly caused by the Registrant, the consequences were nonetheless significant and, in some cases, tragic. Those outcomes cannot be overlooked. The Registrant played a central role in overseeing the systems and processes through which the service was delivered, and the Committee considered that the failings identified had foreseeable and serious real-world consequences for patients.

323. The Registrant put forward mitigation which suggested he tried to make improvements to these systems and governance which the Committee accepts. However, these improvements did not go far enough and ultimately, the fundamental model of UK Meds did not change which was the real issue in this case.

324. The Committee therefore found that its findings of fact in respect of the charges proved were serious enough to amount to serious professional misconduct.

Impairment

325. Having found that misconduct has been established, the Committee went on to consider whether the Registrant's fitness to practise is currently impaired.

326. 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 being, 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."

327. In this regard the Committee also considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* [2011] EWHC 927 (Admin) in reaching its decision. In paragraph 74, she said:

"In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner

continues to present a risk to members of the public in his or her current role, but also 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."

328. In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's guidance which reads as follows:

"Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that s/he:

a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or
d) has in the past acted dishonestly and/or is liable to act dishonestly in the future."

329. These principles are echoed in the Guidance 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".*

330. In considering actual or potential risk to patients or the public, the Committee considered the first question set out above by Mrs Justice Cox in *Grant* in respect of

whether the Registrant has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm.

331. The Committee considered that the conduct and behaviour demonstrated by the Registrant clearly presented an actual risk to patients and the public in that there was real harm caused by the UK Meds model to patients and vulnerable individuals. The Committee heard from concerned patient's relatives, other pharmacy and medical professionals and coroners about the real actual harm which was caused by this business model. The Registrant played a key role in that model for all the reasons already found, including his failure to challenge poor practices like the reliance on a questionnaire and the lack of contact with patients and other healthcare providers and his failure to provide proper leadership for prescribers and pharmacy professionals.

332. In respect of his liability to put patients at risk in the future, the Committee considered whether the Registrant's behaviour was remediable and whether he has shown insight into his behaviour which echoes the guidance cited above at paragraph 2.15 of the Guidance, namely whether the conduct is able to be addressed, whether it has been addressed and whether it's likely to be repeated.

333. The Committee considered that, whilst the failings that occurred during the Registrant's time as SI and RP at UK Meds were serious and far reaching, they did consider such conduct was capable of being remedied. Had the Registrant listened to the concerns of the inspectors at the time and sought to change some of the fundamental issues with the UK Meds model, such as reliance on the questionnaire and failure to record prescribing decisions or contact the GP for medical records, there would have been a marked improvement towards patient safety.

334. Unfortunately, these issues were not addressed and only limited improvements were made, which fell well short of what was required. The Committee has seen little evidence that the Registrant has remediated the failings identified or developed meaningful insight into them. Whilst his submissions suggest reflection and learning,

they remain largely high-level and lack detailed consideration. In particular, the Committee was not persuaded that the Registrant fully appreciates the extent of his accountability for ensuring the safe and effective operation of the pharmacy.

335. The Committee also noted the absence of evidence that the Registrant sought to remediate these concerns during the period of the GPhC inspections. He appeared to maintain an entrenched position and did not adequately address key issues, including the reliance on questionnaires and the lack of direct patient engagement.

336. As SI, and later as a director of UK Meds, the Registrant was in a position to exert influence and drive meaningful change, but the Committee saw little evidence that he did so. Instead, when the UK Meds model came under increasing regulatory scrutiny, the organisation chose to deregister rather than implement the changes that had been identified as necessary.

337. The Committee considered the fact that the Registrant became a director of EU Meds on the same day that UK Meds was deregistered to be highly significant when assessing both his conduct and level of insight. By that stage, the Registrant had been aware for several years of the concerns repeatedly raised by GPhC inspectors regarding the safety and adequacy of the UK Meds model. Despite this, rather than taking meaningful steps to address those concerns, he became involved in the continuation of a substantially similar model operating outside the GPhC's regulatory jurisdiction. In the Committee’s view, this decision demonstrated a failure to fully recognise the seriousness of the concerns that had been raised and undermined his assertion that he had gained sufficient insight into the failings identified.

338. The Registrant sought to persuade the Committee in his latest submissions that he now understands that governance is more than just ensuring systems and policies are in place and that he must be proactive in making sure those systems are working and safeguarding patients. He suggests that the processes he had in place were simply not sufficient and that he has learnt from this. But the Committee considers it

was more than this. The UK Meds model was unsafe. There is no acknowledgment of this by the Registrant. He says he has reflected and learned lessons but he does not say how, he does not go into any detail about how he is better informed, how his thinking has changed and how things would be different today.

339. The Committee considers in light of all this that the conduct has not been addressed and is likely to be repeated.

340. The Committee next turned to consider whether the Registrant has brought the profession into disrepute. In doing so, it has looked at whether the Registrant has breached one of the fundamental principles of the pharmacy profession and whether a finding of impairment is needed to declare and uphold proper standards of behaviour and/or maintain public confidence in the profession.

341. The Committee bore in mind the overarching objectives of the GPhC: to protect, promote and maintain the health, safety and well-being of members of the public and in particular of those members of the public who use or need the services of registrants, or the services provided at a registered pharmacy, be ensuring that registrants and those persons carrying on a retail pharmacy business at a registered pharmacy, adhere to such standards as the Council considers necessary for the safe and effective practice of pharmacy.

342. The Committee considers that the misconduct in this case was exceptionally serious. It has considered the fundamental tenets of the pharmacy profession, which are, amongst other things, providing safe and effective care, acting with integrity and above all, putting patients first. It finds that the Registrant has breached these principles for all the reasons given above.

343. The Registrant acted in a senior role at UK Meds which was a significant player in the world of online prescribing and the concerns that came alongside that. He should have challenge the poor practices he saw and engaged with his regulator. He should have put patient care first and led his pharmacy team with professional skill and

judgement. He did not do any of these things and as a result patients and the public suffered harm. The Committee has heard evidence from professionals such as GPs, pharmacists and emergency care doctors who were rightly appalled and alarmed that their patients were able to obtain high risk medication as easily as they did, some with tragic consequences. It has heard from concerned coroners and members of the press who questioned how this unsafe model was allowed to operate. All of this has clearly brought the profession of pharmacy into disrepute and the Registrant has to bear responsibility for that.

344. There were serious shortcomings in this case and it is difficult to see how public confidence in the profession would not be seriously undermined in a case of this importance and magnitude if a finding of impairment were not made.

345. In that respect, the Committee finds that a finding of current impairment is indeed necessary to declare and uphold proper standards of behaviour and to maintain public confidence in the profession.

346. Having regard to all the above, the Committee was satisfied that Mr Morjaria's fitness to practice is currently impaired by reason of his misconduct.

Decision on Sanction

347. Having found impairment, the Committee has gone on to consider the matter of outcome. The Committee's powers are set out in Article 54(2) of the Order. The Committee should consider the available outcomes in ascending order of severity, beginning with taking no action and progressing to the most restrictive sanction, removal from the Register, in order to determine the sanction that is both appropriate and proportionate in the circumstances of the case.

348. The Committee has reminded itself that the purpose of the outcome is not to be punitive, though a sanction may in fact have a punitive effect. The purpose of the sanction is to meet the overarching objectives of regulation, namely the protection

of the public, the maintenance of public confidence in the pharmacy professions and the regulatory process and to promote professional standards. The Committee is therefore entitled to give greater weight to the public interest over the Registrant's interests.

349. The Committee had regard to the Council's 'Good decision making: Fitness to practise hearings and outcomes guidance' (Revised March 2024) ("the Guidance") to inform its decision.

350. The Committee also had regard to the submissions from Mr Hoskins on behalf of the Council and the submissions provided previously by Mr Morjaria. The Committee understands that Mr Morjaria has been sent its decision on misconduct and impairment and invited to make further representations in respect of outcome, but it has not received any further correspondence from him.

Mr Hoskins' submissions on outcome

351. Mr Hoskins submitted that removal was the only appropriate outcome, arguing that the facts found proved were properly characterised as being fundamentally incompatible with registration as a pharmacist.

352. Mr Hoskins said that following the Guidance, taking no action, giving a warning or advice would not be appropriate given the ongoing risk identified by the Committee. He also submitted that conditions would not be appropriate as these should only be utilised where the Committee was satisfied that the Registrant may respond positively to retraining and supervision. Mr Hoskins submitted that whilst there was some evidence of this, it was all theoretical and did not factor in the practicality of such an option. He said the evidence before the Committee suggested that Mr Morjaria would not respond positively to conditions. Mr Hoskins also reminded the Committee that the Guidance suggests that conditions are only appropriate when there is not a significant risk to the public and it is safe to return to practice with conditions. He suggested that the Committee's findings on impairment clearly contradicted this.

353. Mr Hoskins submitted that the Committee should next consider suspension but maintained that removal is the only appropriate outcome in this case. That is because he says Mr Morjaria's conduct is fundamentally incompatible with continued registration and falls clearly within the most serious category of misconduct. This submission is based on the Committee's findings at the impairment stage and the identified risk of this being an exceptionally serious case with a risk of patient harm and repetition.

354. Mr Hoskins submitted that, when considering whether the conduct was fundamentally incompatible with continued registration as a professional, the Committee should take into account not only the risk posed by the Registrant but also the need to maintain public confidence in the profession and the regulatory process. He argued that, given the seriousness of the risks involved and the nature of the behaviour identified in this case, which was at the very highest end of harm and could even be described as dangerous, only removal would be appropriate.

Mr Morjaria submissions on outcome

355. Mr Morjaria did not make any further submissions at the outcome stage, but the Committee has borne in mind his previous submissions and reflections.

Decision on outcome

356. The Committee accepted the advice of the Legal Assessor.

357. The Committee considered that the following previously identified factors demonstrated the seriousness of Mr Morjaria's misconduct:

- Duration and persistence of the behaviour which continued over several years
- Numerous opportunities when matters could have been improved and addressed but these were resisted
- Despite knowing of serious safety concerns with the operating model of UK Meds, as identified by GPhC inspectors, joined the Board and

helped establish EU

Meds in an apparent attempt to circumvent regulation

- Real risk of the highest level of harm which had a significant impact on patients
- Transactional model which put commercial profit over patient safety.
- Senior positions held – in a leading role at UK Meds with influence at board level
- Experienced pharmacist who was capable and aware of what good practice should look like.
- Did not ensure prescribers were following guidance and policies available
- Failed to demonstrate effective leadership
- Limited insight into his behaviour

358. The Committee identified the following mitigating factors:

- No previous regulatory concerns
- Some improvements made with good intention
- A level of partial insight in that the Registrant now says he wished he had behaved differently
- Expressions of regret as to what happened to patients

359. The Committee also considered points Mr Morjaria put forward as possible mitigation, such as the rapidly changing environment that he was working in during that time. The Committee has already stated in its findings at stage 2, that it did not consider this to be an adequate explanation for the deficiencies identified. Pharmacy professionals are expected to maintain, develop and apply their knowledge and skills in response to changes in professional practice and the wider healthcare environment. The changing nature of online prescribing and remote healthcare increased, rather than diminished, the need for robust professional oversight. The Committee considered that the Registrant should have ensured that his knowledge and understanding evolved accordingly so that he could discharge his responsibilities as SI effectively and safeguard patients.

360. The Committee also accepts that Mr Morjaria's actions were reckless rather than deliberate.

361. The Committee considered the testimonials Mr Morjaria provided:

1. AS – this is a relatively old testimonial, provided in July 2022 by another pharmacist who worked at UK Meds. His opinion of the Registrant which suggests that he "*made patient safety his priority*" and worked to a high standard directly conflicts with the Committee's own findings. The Committee notes also that Mr AS has been the subject of his own fitness to practise proceedings. It therefore considers this testimonial to be of very limited assistance.

2. JS – this is another old testimonial from July 2022 provided by one of the directors of UK Meds who at the time this testimonial was provided had already removed UK Meds from GPhC oversight and regulation. The Committee noted that the testimonial is openly critical of the GPhC and its investigation process. In the Committee's view, this detracts from its objectivity and accordingly affects the weight that can be placed upon it.

3. AL – this testimonial is also old as it dates from July 2022. It seems to be a colleague of the Registrant at UK Pets. While she speaks highly about the Registrant's drafting of SOPs, this does not assist with the Committee's concerns, which relate to his ability to audit relevant procedures and assure himself of the effectiveness of those policies.

4. AK – again, an old testimonial from someone who, in this case, does not appear to have worked with Mr Morjaria. Whilst Mr AK speaks highly of the Registrant in a personal capacity, describing him as a very warm, good hearted and friendly gentleman (which the Committee has no reason to doubt) he does not address the Committee's fundamental concerns about Mr Morjaria's professional capabilities and fitness to practise.

5. RK – again, an old testimonial whereby Mr Morjaria is spoken about very highly in a personal capacity but similar to the previous reference from Mr RK, this does not address the Committee's concerns about his fitness to practise.

362. The Committee went on to consider the available sanctions in ascending order from least restrictive to most restrictive; in order to identify the least restrictive sanction that in these circumstances adequately addresses the overarching objectives of regulation; namely the protection of the public, the maintenance of public confidence and the need to promote professional standards.

363. To take no action: The Guidance indicates that this sanction is appropriate where there is no risk to the public. The Committee does not consider that to be the case here. Furthermore, given the seriousness of the misconduct, the Committee considers that such a sanction would be insufficient to meet the wider public interest.

364. Advice: The Guidance indicates that this sanction is appropriate where there is no continuing risk to patients or the public. The Committee has already determined that such a risk remains in this case. The Guidance also suggests that this outcome may be appropriate where there is no need to restrict a professional's right to practise. However, given the seriousness of the misconduct, the Committee considers that the public interest requires regulatory action that places a restriction on the Registrant's practice.

365. Warning: The Guidance indicates that this sanction is appropriate where there is no need to restrict a professional's right to practise and there is no continuing risk to patients or the public. The Committee does not consider those circumstances apply in this case. It has found that a continuing risk to the public remains and considers that, given the seriousness of the misconduct, the public interest requires a sanction that imposes a restriction on the Registrant's practice.

366. Conditions of Registration: The Committee next considered the imposition of conditions on Mr Morjaria's registration. Applying conditions on his registration would allow Mr Morjaria to practise albeit with restrictions. The Committee considered whether conditions would remedy the concerns it had and protect the public maintain public confidence and promote professional standards.

367. The Committee noted that Mr Morjaria is an experienced pharmacist and there is nothing to suggest that, at least, in theory he could be capable of safe practice. The Committee has carefully considered whether conditions of practice could adequately address the concerns identified in relation to the Registrant's fitness to practise.

368. However, it is not satisfied that workable or effective conditions could be formulated in this case. It took into account his history of working in senior roles and therefore had concerns about both the practicality of close supervision and the extent to which he would respond positively to retraining, monitoring, and oversight.

369. Conditions of practice are often most effective where there is a clearly identifiable area of concern that can be addressed through targeted restrictions, supervision, or training. However, in Mr Morjaria's case, the Committee's concerns are broad-ranging and extend beyond clinical competence to attitudinal issues. The Committee does not consider that such concerns could be adequately addressed through conditions of practice.

370. The Committee has also considered what Mr Morjaria said previously in his submissions under the heading of 'present position and future intentions' which was that since leaving UK Meds, he has not returned to pharmacy practice and has moved forward professionally in other areas and rebuilt his life outside pharmacy. He said *"[a]t present, I have no intention of seeking restoration. I do not make that statement lightly. Pharmacy represented many years of study, commitment and personal investment. However, after prolonged reflection, I have reached the view that this chapter of my life has come to an end".* The Committee therefore does not

consider that Mr Morjaria would engage meaningfully with conditions of practice or be likely to comply with them.

371. The Committee also considered that conditions of practice would not adequately address the risk posed by Mr Morjaria. Further, it concluded that conditions would be insufficient to maintain public confidence in the profession and uphold proper professional standards, given the seriousness of the misconduct and the level of risk identified. The Committee therefore determined that conditions of registration would not be an appropriate or proportionate sanction.

372. Suspension: The Guidance states that suspension may be appropriate when:

"*The committee considers that a warning or conditions are not sufficient to deal with any risk to patient safety or to protect the public, or would undermine public confidence. When it is necessary to highlight to the profession and the public that the conduct of the professional is unacceptable and unbefitting a member of the pharmacy profession. Also when public confidence in the profession demands no lesser outcome."*

373. The Committee has concluded that no lesser outcome is acceptable and therefore considered whether suspension could satisfy the objectives.

374. The Committee considers this to be an exceptionally serious pattern of misconduct which lasted over several years and which caused profound damage to the reputation of the pharmacy profession. Whilst it demonstrates behaviour which is certainly unacceptable and unbefitting a member of the pharmacy profession, this outcome does not go far enough to address the Committee's concerns.

375. The Registrant held the most senior pharmaceutical position at UK Meds in his capacity as SI. Despite being made aware of the concerns identified by GPhC inspectors and being given numerous opportunities to address them, the deficiencies and poor practices at UK Meds persisted. The Committee noted that these continued over a significant period and did so under the Registrant's oversight and responsibility.

376. The Committee considered that the scale of prescribing of high-risk medications in unsafe conditions, together with the very real potential for patient harm, could not be ignored. It concluded that members of the public, including patients and families affected by the practices at UK Meds, as well as healthcare professionals who raised concerns, would be shocked if the Registrant, who presided over repeated and serious failings over an extended period, were permitted to return to practice following a period of suspension. Consequently, the Committee determined that suspension would be insufficient to maintain public confidence in the profession and uphold proper professional standards.

377. Removal: In relation to removing a pharmacist from the register, the Guidance states:

"Removing a professional's registration is reserved for the most serious conduct. The committee cannot choose this outcome in cases which relate solely to the professional's health. The committee should consider this outcome when the professional's behaviour is fundamentally incompatible with being a registered professional"

378. The Committee concluded that this case is so serious that public confidence in the profession would be undermined if the Registrant were not removed from the register. It considered that a clear and unequivocal message must be sent that such sustained poor and unsafe practice is wholly unacceptable and fundamentally incompatible with continued registration as a pharmacist. The Committee is satisfied that only removal from the register would sufficiently mark the seriousness of the misconduct, maintain public confidence in the profession, and uphold proper professional standards.

379. The Committee considered that Mr Morjaria had persistently departed from fundamental principles of safe prescribing practice and patient safety. It found that, over a sustained period, he participated in practices that prioritised commercial objectives over the delivery of safe and effective patient care, thereby creating a real risk of the most serious levels of harm to patients.

380. The Committee considers that this behaviour is fundamentally incompatible with being a registered professional such that members of the public would lose

confidence in the profession and the regulator were Mr Morjaria to remain registered. The Committee also considered that fellow professionals would regard the misconduct as being so far removed from the standards, values, and principles expected of a registered pharmacist that allowing the Registrant to remain on the register would undermine and denigrate professional standards.

381. The Committee finds that the only outcome that can meet the overarching objectives of regulation, namely the protection of the public, the maintenance of public confidence and to promote professional standards is removal from the register.

The Committee therefore directs that the Registrar removes Mr Morjaria from the register.

Decision on Interim Measure

382. The findings of this Committee mean that the previous interim order is revoked.

383. The Committee went on to consider interim measures. Interim measures are provided for under Article 60 of the Order and may be imposed after an order for removal, suspension or conditions of registration. A committee can only impose interim measures if it is satisfied that they are needed to protect the public, or are otherwise in the public interest or in the interests of the professional. Any interim measures will take effect immediately and can cover the 28-day 'appeal period'. If the decision is appealed, the measures will stay in force until that appeal is decided.

384. Mr Hoskins submitted on behalf of the Council that an interim measure of suspension was required for public protection and public interest reasons given the findings of the Committee at previous stages of the proceedings.

385. The Committee did not have any evidence or submissions from the Registrant.

386. The Committee considered that the ongoing risks it has previously identified relating to repeated and sustained unsafe practices at UK Meds under the Registrant's supervision, the actual risk of patient harm and his having not remediated these matters, mean that an interim suspension measure is necessary for public protection. The Committee considers that there are immediate risks posed to the public. Further given this position and the reasons outlined above, the Committee considers public trust and confidence in the profession, and the regulator would be undermined if the Registrant was not restricted from practicing before being removed from the register. The Committee is satisfied that it is necessary for an interim measure to be put in place to protect the public and safeguard the public interest during the appeal period. The Committee is satisfied that it is therefore appropriate and proportionate for an interim suspension to be in place prior to the Registrant being removed from the register.

387. The Committee hereby orders that the entry of the Registrant in the register be suspended forthwith, pending the coming into force of the substantive order.

388. This concludes the determination.