

General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

In person at Cabot Square, Canary Wharf

21 January 2026 to 27 January 2026

2 April 2026

7 September 2026 to 8 September 2026

Registrant name: Dharmesh Nilesh Bhagat

Registration number: 2229853

Part of the register: Pharmacist

Type of Case: Misconduct

Committee Members: Anthony James (Chair)

Sima Hassan (Registrant member)

Jo Bower (Lay member)

Committee Secretary: Evie Davies and Ivana Raimundova

Registrant: Present and represented by Kevin McCartney
(counsel) instructed by Temple Bright LLP

General Pharmaceutical Council: Represented by Simeon Wallis (counsel), Case
Presenter

Facts proved:	4.1.1, 4.1.2, 4.1.3, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.11, 6
Facts proved by admission:	1, 2, 3, 5
Facts not proved:	4.8, 4.10, 8
Fitness to practise:	Impaired
Outcome:	3-month suspension

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 **7 October 2026** or, if an appeal is lodged, once that appeal has been concluded.

Particulars of Allegation (as amended)

You, a Registered Pharmacist, between January and December 2022:

1. Worked as the regular second Pharmacist at Lords Dispensing Chemist, 35 Station Parade, Barking, 1G11 8EB (“the Pharmacy”); **[ADMITTED]**
2. On 20 occasions, worked as the Responsible Pharmacist at the Pharmacy **[ADMITTED]**
3. Whilst working as the regular second Pharmacist and Responsible Pharmacist, knew that the Pharmacy was engaged in dispensing and supplying medication prescribed by a prescribing service and trading platform, Healthinfoservices Limited, including controlled drugs and including to overseas patients; **[ADMITTED]**
4. Whilst working as the regular second Pharmacist and Responsible Pharmacist, took no or no effective steps to ensure that the Pharmacy’s supplies at paragraph 3 above were conducted safely and / or legally in that: **[PROVED]**

4.1 The medicines supplied by the Pharmacy included:

- 4.1.1 Opioid-based painkillers **[PROVED]**
- 4.1.2 Benzodiazepines **[PROVED]**
- 4.1.3 Sleeping tablets **[PROVED]**
- 4.1.4 Gabapentin **[NO CASE TO ANSWER]**
- 4.1.5 Pregabalin. **[NO CASE TO ANSWER]**

4.2 Audits were not carried out to determine the suitability of the prescribing to verify the safety and quality of the dispensing service **[PROVED]**

4.3 There were no records to justify why prescriptions were issued and dispensed **[PROVED]**

- 4.4 On inspection on 20 December 2022, there was no information to show how patient's identification was checked **[PROVED]**
- 4.5 There were no written risk assessments for medications and treatments dispensed and supplied **[PROVED]**
- 4.6 On inspection on 20 December 2022, there was no information to show how patients were safeguarded against the medications which were highly addictive and subjected to abuse; **[PROVED]**
- 4.7 There were no specific Standard Operating Procedures in place for the dispensing service provided; **[PROVED]**
- 4.8 There was no service agreement to define the relationship and terms between the pharmacy and the prescribing service **[NOT PROVED]**
- 4.9 Private prescription records were not kept for the medicines dispensed and supplied on behalf of Healthinfoservices Limited; **[NO CASE TO ANSWER]**
- 4.10 Adequate insurance was not in place to cover the supply of medication to patients in the USA or Canada **[NOT PROVED]**
- 4.11 The Pharmacy had no export licence **[PROVED]**
5. On an unknown number of occasions, completed Customs Declaration labels for outgoing packages containing controlled drugs and recorded "health supplements" under the heading "description of contents"; **[ADMITTED]**
6. Your actions at 5 above were dishonest in that you knew that some of the packages contained controlled drugs and that "health supplements" was an inaccurate and misleading description of the contents; **[PROVED]**
7. Alternatively, your actions at 5 above lacked integrity inasmuch as the completion of Customs Declaration labels called for accurate information and you did not ensure the description reflected the inclusion of controlled drugs in the packages; **[ALTERNATIVE]**

8. On 20 December 2022, did not ensure that controlled drugs, including methadone, were stored securely in accordance with The Misuse of Drugs (Safe Custody) Regulations 1973; **[NOT PROVED]**

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

Documentation

Document 1- Council's hearing bundle

Document 2- Excel spreadsheet of prescription reports

Document 3- Council's skeleton argument

Document 4- Registrant's bundle

Document 5- Extracts from Ms 1's contemporaneous notes

Witnesses

Ms 1, GPhC Inspector - gave evidence at facts stage

Mr 2, Senior Criminal Enforcement Officer – evidence received in writing at facts stage

Mr 3, Head of Firearms & Import/Export Drugs Licensing at the Home Office - evidence received in writing at facts stage

Mr 4, GPhC Case Administrator - evidence received in writing at facts stage

Determination

Introduction

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

Stage 1. Findings of Fact – the Committee determines any disputed facts.

Stage 2. Findings of ground(s) of misconduct and impairment – the Committee determines whether, on the facts as proved, a statutory ground for impairment is established and, if so, whether the Registrant's fitness to practise is currently impaired.

Stage 3. Outcome – the Committee considers what, if any, outcome should be applied if the Registrant's fitness to practise is found to be impaired.

Service of Notice of Hearing

6. The Committee has seen a letter dated 23 December 2025 from the Council headed 'Notice of Hearing' addressed to the Registrant and sent to their registered email address as noted on the Register. No issue was taken with service by either party.

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

Application to amend the particulars of allegation

8. The Committee heard an application from the Case Presenter under Rule 41 to amend the numbering in particular 4.1 to correct it to say 4.1.1 etc as opposed to 2.4.1 etc.
9. Mr McCartney agreed with the proposed amendments.
10. The Committee was of the view no prejudice was caused by this typographical error and made the amendment to make the structure of the allegations clear.

Registrant's response to particulars of allegation

11. The Registrant admitted particulars 1, 2, 3 and 5. Mr McCartney did make clear in respect of allegation 3 that the extent of the Registrant's knowledge of the operation was still in dispute.
12. In the light of the above, and by the application of Rule 31(6) of the Rules, the admitted factual particulars were found proved.
13. The Committee went on to receive evidence and submissions regarding the remaining disputed particulars.

Background according to the Council

14. The Registrant first registered as a pharmacist with the Council on 1 January 2022. At the time of the allegations, the Registrant was working at Lords Dispensing Chemist, 35 Station Parade, Barking, IG11 8EB ("the Pharmacy"). A Mr HP was the

superintendent pharmacist and the Registrant, the second pharmacist. On 20 occasions in 2022, the Registrant acted as the responsible pharmacist.

15. On 20 December 2022, Ms 1 (a Council Inspector) attended the Pharmacy on a targeted visit to investigate the possibility that the Pharmacy was involved in the supply of various medications including controlled drugs to the United States of America. Both HP and the Registrant were present during this visit.
16. Ms 1 discovered multiple packages of controlled drugs (“CDs”) outside of the controlled drugs cabinet in the dispensary area. Further, a large volume of expired and patient returned CDs as well as methadone was found stored under a workbench in the office and outside of the CD cabinet.
17. Ms 1 also found grey postage bags labelled to be sent to the USA. These contained mainly Schedule 4 and 5 CDs. Prescriptions for patients in the USA were also found on a workbench. HP informed Ms 1 that the Pharmacy had been dispensing prescriptions issued by an EU based prescribing service called HealthInfoServices Ltd for three years. All the prescriptions seen in the pharmacy on the day had been issued by an EU prescriber who was based in Bulgaria. This online service was not registered with any UK regulator. For the remainder of the determination, the Committee will refer to the service as “the Online Prescribing Service”.
18. Ms 1 was concerned, following some investigation which included her conversation with HP, about the following:
 - a. The Pharmacy had not completed any risk assessments prior to initiating or throughout the course of providing this service;
 - b. There were no specific standard operating procedures (SOPs) in place to support the services it provided in association with the Online Prescribing Service;
 - c. There was no service agreement to define the relationship and terms between the Pharmacy and the Online Prescribing Service;

- d. The Pharmacy had not carried out any audits to determine the suitability of the prescribing nor had it analysed the prescribing habits which could help verify the safety and quality of the service being provided;
 - e. HP was unaware whether the prescribers ever contacted patients as part of the consultation process;
 - f. There was no evidence that any information had been shared with patient's regular prescribers;
 - g. There were no records or notes to show justification for prescribing or why prescriptions had been issued without contacting the patient's regular GP;
 - h. There was no information on how patients' ID was checked;
 - i. The Pharmacy received the prescriptions from the service electronically and the dispensed medicines were sent by courier directly to the patients. The pharmacy did not have any other contact with the patients or prescribers;
 - j. Most patients who accessed the service were from the USA. HP said he believed there were some rules about sending medicines to the USA, but he had not done too many checks;
 - k. The Pharmacy did not have adequate indemnity insurance cover to supply medicines to patients living in the USA or Canada;
 - l. The Pharmacy had not kept any private prescription records for the medicines it dispensed and supplied as part of this service.
19. These concerns were set out in notices to impose conditions on the Pharmacy on 23 December 2022 and 13 January 2023 as well as Ms 1's witness statement from October 2023. The Committee also had sight of extracts from Ms 1's notebook, which she used during her visit on 20 December 2022. These notes stated:
- a. "private Rx records electronic"
 - b. "Rx details not on there"

- c. “hasn’t done any audits + risk assessments”
 - d. “no SOPs”
 - e. “hasn’t in his possession got a contract or SLA”
20. Later checks showed that HP was registered as a director of HealthInfoServices on Companies House. The company’s registered address was also that of the Pharmacy’s.
 21. Some of the grey packages containing CDs that were to be sent abroad had customs declarations affixed to them. The description of the contents of these packages was labelled “health supplements”. The Registrant informed Ms 1 during her visit that he had completed labels in that way having been told to by HealthInfoServices.
 22. During the visit, Ms 1 also assisted the Registrant to find a spreadsheet setting out the record of CDs dispensed overseas using the service.
 23. Mr 4, a GPhC Administrator, subsequently analysed prescription data for the year 2022. This research suggested that there were approximately 732 patients in 11 countries served by the Online Prescribing Service. Approximately 3499 items were prescribed between January and December 2022.
 24. On 10 March 2023, the Registrant, through his legal representatives, provided the Council with various documentation that included:
 - a. Insurance policy certificates for the Pharmacy from 2017 to 2023;
 - b. Standard Operating Procedures for overseas dispensing and prescribing;
 - c. A spreadsheet setting out records of CDs dispensed overseas;
 - d. The service level agreement between HealthInfoServices Ltd and Lords Pharmacy; and
 - e. A copy of the responsible pharmacist logs for 2022.

Application of no case to answer

25. After the Council had closed its case on the facts, the Committee received and considered an application from Mr McCartney under rule 31 (8) that there was no case to answer in respect of the following:
- a. The entirety of the stem of allegation 4 and in the alternative the following sub-parts of the allegations:
 - i. 4.1.4;
 - ii. 4.1.5;
 - iii. 4.4;
 - iv. 4.6 in respect of “and subjected to abuse”;
 - v. 4.7;
 - vi. 4.8;
 - vii. 4.9;
 - viii. 4.10 in respect of “or Canada”;
 - b. The entirety of allegation 8.
26. The Committee received and considered submissions from the Case Presenter. No submissions were made by the Council in respect of:
- a. 4.1.4;
 - b. 4.1.5;
 - c. 4.6 in respect of “and subjected to abuse”;
 - d. 4.9;
 - e. 4.10 in respect of “or Canada”.
27. The Committee took into account the guidance in the case of *R v Galbraith* [1981] 1 W.L.R. 1039 and asked itself whether the evidence adduced so far placed the case into either of the following two categories:

- (1) That there was no evidence that the Registrant had carried out the acts or omissions alleged in any / all of the particulars;
 - (2) That there was some evidence but that it was of a vague or tenuous character such that no tribunal, taking the evidence at its highest and properly directing itself could find the particulars proven on the balance of probabilities.
28. The Committee bore in mind the following passage from the judgment in Galbraith:
Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witnesses [sic] reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence on which the jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury.
29. The Committee was mindful that taking the Council's evidence at its highest does not mean selecting only those parts of the evidence that support the Council's case and we must consider all of the evidence as a whole.
30. In this case we consider that there is no case to answer in respect of allegations:
 - a. 4.1.4;
 - b. 4.1.5;
 - c. 4.6 in respect of "and subjected to abuse";
 - d. 4.9;
 - e. 4.10 in respect of "or Canada".
31. We consider that there is a case to answer on the remaining allegations for the following reasons.

Stem of Allegation 4

32. Mr McCartney submitted that the Council had failed to adduce sufficient evidence that the Registrant was under an obligation to ensure that any steps or any effective steps were taken to ensure that the supply of medication prescribed by HealthInfoServices was conducted safely and/or legally. He relied on the following:
- a. The Registrant played a limited role in the Online Prescribing Service by filling out customs declaration labels. Unless there was evidence that the Registrant was aware of any systems failure, he was under no professional obligation to ensure the safety and legality of systems. There was no evidence of such knowledge. HP remained the superintendent pharmacist ("SI") and owner and he was the one dealing with prescriptions and online supply. Therefore in his role as second pharmacist, which was the majority of the time in 2022, no obligation arose for the Registrant to ensure the safety/legality of the Online Prescribing Service.
 - b. Even when the Registrant was the responsible pharmacist, the Council have to prove that any obligation under section 72A Medicines Act 1968 established a duty to ensure the safe systems for online supplies by HP as the owner and SI. That interpretation would stretch the provisions too widely and have a considerable impact on the role of pharmacists working in the UK. If that were the case, any responsible pharmacist working on an individual day would be responsible for safe systems no matter the size of the pharmacy e.g. a locum RP at Boots in Piccadilly would be responsible for the entirety of the click and collect service being operated from that branch. Similarly, a locum would also have to review all systems for advanced or enhanced services on the one day they were working at a particular pharmacy.
33. The Case Presenter resisted these submissions on the basis that the Registrant was under obligations at all times as a pharmacist and also additional obligations on the days he was acting as the responsible pharmacist. His general obligations flowed from the Standards for Pharmacy Professionals. He was one of two pharmacists working in the Pharmacy each working day providing an online service of which he was aware by the fact of his admission to allegation 3 and involvement with the customs declaration labels. This service was taking place continuously over 2022 on

days immediately before, on and after those when the Registrant was acting as the responsible pharmacist. When obligations apply depends on a state of knowledge that is fact specific. Inferences can be drawn from the size of the organisation and the Registrant's specific role in making declarations as regards the content of packages. There was ample evidence that a pharmacist adhering to the Standards would have asked questions of HP and if given unsatisfactory answers to challenge the lack of safeguards as poor practice. A pharmacist is not entitled simply to turn a blind eye. As regards the role of the Registrant as the responsible pharmacist, section 72A places specific obligations to secure the safe running of the pharmacy. The fact there is an SI or owner does not absolve the responsible pharmacist of applying the Standards. This case is distinct from the examples given by Mr McCartney.

34. The Committee considered that there was sufficient evidence for a tribunal properly directed to find that the Registrant was under an obligation to ensure that any steps or any effective steps were taken to ensure that the supply of medication prescribed by HealthInfoServices was conducted safely and/or legally.
35. Fundamentally, this was a question of fact and degree that distinguished this particular case from the examples cited by Mr McCartney. This was not a case where a locum responsible pharmacist or indeed any pharmacist was handing over click and collect items provided by a large, national company such as Boots. In any event, the Committee was not aware of such "click and collect" services for prescription only medication. The Committee did not consider that the analogy was therefore applicable. If a repeat prescription were ordered online, a pharmacist would be under a duty to ensure its safe and legal supply to a patient.
36. The evidence adduced by the Council so far showed that the Registrant was one of two pharmacists working on a daily basis at a pharmacy with the Online Prescribing Service that provided approximately 3499 items between January and December 2022. Further, there was an admission from the Registrant that he had, on multiple occasions, inputted false data on customs declaration forms to state that packages containing CDs were "health supplements". All of this taken together was such as to

lead the Committee to consider that a panel could find that these facts placed a duty on the Registrant as a regulated pharmacist generally to take steps to ensure that the Online Prescribing Service was conducted safely/legally. In addition, there was sufficient evidence that the Pharmacy was dispensing medication prescribed by the Online Prescribing Service when the Registrant was the responsible pharmacist. Again, given the nature of this particular pharmacy, a panel could conclude he was under an obligation under section 72A to ensure the safe and effective running of the Pharmacy, which included the online operation.

37. The Committee therefore went on to consider the submissions made in the alternative regarding particular sub-allegations in allegation 4.

Allegations 4.1.4 and 4.1.5

38. Given the Council's concession that there was no evidence that Gabapentin and Pregabalin were supplied by the Pharmacy, the Committee found there was no case to answer on these allegations.

Allegation 4.4

39. Mr McCartney submitted that Ms 1 was asked about this allegation and stated that there was no record in her notebook about her assertion in her witness statement of there being no information to show how patient ID was checked. However, it was known from the standard operating procedures on the Online Prescribing Service supplied by the Registrant in March 2023 that there was a procedure. A more general submission was also made about Ms 1's reliability and credibility. Her evidence was based on her recollection of a conversation with HP. Further, her assertion that there was no service level agreement between the Pharmacy and HealthInfoService was undermined by her contemporaneous notebook that stated "hasn't in his possession got a contract or SLA". Further, her claim that there were no private prescription records was undermined by the fact that she assisted the

Registrant to obtain the data that made up Exhibit 2. Ms 1 sought to explain this discrepancy by stating that the detail of the private records was not compliant. These matters were such as to undermine her evidence to the extent that it was so tenuous, there was no case to answer in light of it.

40. The Case Presenter submitted that the inconsistency between the notebook and the witness statement does not invalidate the claim itself. Ms 1's answers were given under the pressure of cross-examination. Ms 1 gave an answer that may at first blush have appeared evasive but was sensible. She stated that in her notebook there was reference to the fact there was no communication with patients.
41. The Committee considered that there was some evidence supporting this allegation. There was Ms 1's assertion in her witness statement that was drawn from the notice of conditions dated 23 December 2022, some 3 days after the visit. Indeed, that notice stated "there was no information provided on how people's ID was checked". Given this relatively contemporaneous note, the Committee considered that a panel could find this charge proved. Questions of credibility, reliability and the weight to be attached to the evidence were matters best answered at the conclusion of the evidence. The concerns raised by Mr McCartney did not render Ms 1's evidence so tenuous that a panel could not find allegations proved in light of it.

Allegation 4.6

42. Mr McCartney submitted that there was no evidence that the drugs supplied by the Online Prescribing Service were "subjected to abuse" in the literal sense.
43. The Case Presenter submitted that his interpretation was that this related to the risk presented by the relevant medication. He suggested the words "and subjected to abuse" be removed. Mr McCartney did not object to this.
44. The Committee initially asked for views of the advocates whether to amend the wording to "and susceptible to abuse". Mr McCartney objected and the Case Presenter felt this wording to be tautologous. The Committee therefore simply

removed the wording “and subjected to abuse”. It was felt that the mischief caught by this allegation was sufficiently clear in its amended form and there was a case to answer in respect of it.

Allegation 4.7

45. Mr McCartney again relied upon his submissions on credibility and reliability. He further stated that the evidence showed that there was an SOP and it was supplied at a later date by the Registrant.
46. The Case Presenter submitted that the Committee could rely on the notebook entry which stated “no SOPs”, which was consistent with Ms 1’s witness statement. 3 months went by before the SOP was provided by the Registrant. It was not an unfair inference to be drawn that the SOP was not in existence at the time of visit on 20 December 2022.
47. The Committee considered that Ms 1’s evidence on this allegation was supported not only by her notebook but also by the notices to impose conditions on the Pharmacy. Notably, by the time of the notice dated 13 January 2023, no SOP had been furnished on Ms 1. There was therefore sufficient evidence for a Panel to find there was no SOP in place in 2022. Again, questions of credibility, reliability and the weight to be attached to the evidence were matters best answered at the conclusion of the evidence. The concerns raised by Mr McCartney did not render Ms 1’s evidence so tenuous that a panel could not find allegations proved in light of it.

Allegation 4.8

48. Mr McCartney again relied upon his submissions on credibility and reliability. He further stated that the evidence showed that there was a service agreement and it was supplied at a later date by the Registrant. In addition, he submitted that the

notebook entry “hasn’t in his possession got a contract or SLA” was distinct from the SOP. The entry was inconsistent with Ms 1’s assertion that there was no SLA.

49. The Case Presenter submitted that the notebook entry could mean “I don’t have possession right now” but could also mean “I don’t have one”.
50. The Committee considered that a panel could agree with the Case Presenter’s formulation. Further, Ms 1’s assertion in her witness statement was drawn from the notice of conditions dated 23 December 2022, some 3 days after the visit. Indeed, that notice stated “There was no service agreement to define the relationship and terms between the pharmacy and the prescribing service”. Given this relatively contemporaneous note, the Committee considered that a panel could find this charge proved. Questions of credibility, reliability and the weight to be attached to the evidence were matters best answered at the conclusion of the evidence. The concerns raised by Mr McCartney did not render Ms 1’s evidence so tenuous that a panel could not find allegations proved in light of it.

Allegation 4.9

51. The Case Presenter conceded that the fact that the Registrant provided Ms 1 with Exhibit 2 at the time of the visit on 20 December 2022 meant that private prescription records were indeed kept. Their adequacy was perhaps a matter of dispute but the strict wording of the allegation was such that there was insufficient evidence.
52. The Committee agreed with the Case Presenter’s analysis and found there was no case to answer on this allegation.

Allegation 4.10

53. The Case Presenter conceded that there was no evidence of the supply of medication to patients in Canada. He invited the Committee to remove the words “or Canada”. Mr McCartney did not object. The Committee agreed with this approach.

Allegation 8

54. Mr McCartney submitted that this allegation turned on the definition of “stored securely in accordance with The Misuse of Drugs (Safe Custody) Regulations 1973”. He drew the Committee’s attention to the following relevant extracts of regulation 3:

(3) [...] the occupier and every person concerned in the management of any premises to which this Regulation applies shall ensure that all controlled drugs (other than those specified in Schedule 1 to these Regulations) on the premises are, so far as circumstances permit, kept in a locked safe, cabinet or room which is so constructed and maintained as to prevent unauthorised access to the drugs.

(4) It shall not be necessary to comply with the requirements of paragraph (2) of this Regulation in respect of any controlled drug which is for the time being under the direct personal supervision of—

[...] (a) a pharmacist

55. Mr McCartney submitted that the evidence was such that all of the controlled drugs were found either in the dispensary or the office adjacent to the dispensary. Both the Registrant and HP were in this part of the Pharmacy at the time of Ms 1’s visit. The medication was accordingly under one or both of their direct personal supervision at the relevant time, namely 20 December 2022. He referred the committee to the following cases: Roberts v Littlewoods Mail Order Stores Ltd [1943] KB 269 at 272 per Visc Caldecote CJ and 273 per Humphreys J and Pharmaceutical Society of Great Britain v Boots Cash Chemists (Southern) Ltd [1953] 1 QB 401. He

submitted that there was no case law on all fours with the statutory language in question but that direct personal supervision should be taken to mean that a pharmacist would have the ability to act if a member of the public were to come in and decide to steal one of the CDs. They would have supervision and would be able to act in such circumstances.

56. The Case Presenter responded that there was a difference between merely being present in the same room as the CDs, some of which were under a workbench with an eyeline to them and direct and personal supervision of the drugs. The wording imports something much closer than having the object in sight at all times.
57. The Committee considered that a panel could conclude that direct personal supervision in the context of Schedule 2 and 3 CDs imported a greater duty on a pharmacist than mere presence in a room with the CDs. Further, the haphazard nature of the way in which a large volume of CDs were stored in this case (some CDs in a mixture of closed plastic bags and cardboard boxes) meant that a panel could conclude that the pharmacists did not know sufficient detail about the drugs in the room to be able to exert any control over the drugs. A non-pharmacist member of staff for example could enter the room and take a CD without the pharmacists' knowledge. This was a scenario very different to the obvious need to remove CDs from a CD cabinet to then dispense them to patients or a pharmacist turning his back on some CDs when undertaking a task momentarily.
58. The Committee found that there was a case to answer in respect of allegation 8.

Decision on Facts

59. 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 Mr McCartney.
60. The Committee was given legal advice in respect of:
 - a. The burden and standard of proof;

- b. Separate consideration of each allegation;
 - c. Inferences from circumstantial evidence in respect of allegation 8;
 - d. Good character;
 - e. Dishonesty;
 - f. Integrity.
61. 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.

Stem of Allegation 4

4 Whilst working as the regular second Pharmacist and Responsible Pharmacist, took no or no effective steps to ensure that the Pharmacy's supplies at paragraph 3 above were conducted safely and / or legally

62. The Committee agreed with the parties that it should consider the “stem” of allegation 4 before then going on to consider the individual aspects thereof. The Committee had to consider whether the Council had discharged the burden of proof by showing that the Registrant had a duty both generally under the Standards and in accordance with section 72A Medicines Act 1968 when acting as RP to take effective steps to ensure the Online Prescribing Service was conducted safely and/or legally.
63. The Committee considered that it was a question of fact and degree as to whether a particular pharmacist comes under a duty to ensure safe and legal supply of medication via an online service such as that carried out by the Pharmacy. Duties under the Standards or indeed section 72A do not necessarily require a pharmacist to double check pre-bagged medicines ready for collection by patients on a later date when they were not the pharmacist who had done the clinical and accuracy check on an earlier date as submitted by Mr McCartney.

64. In the instant case, the Registrant's role was such as to place him under a duty to take effective steps to ensure the Online Prescribing Service was prescribing and supplying safely and legally. The Registrant was one of two pharmacists working on a daily basis at a pharmacy with a related online operation that supplied approximately 3499 items (the vast majority of which were CDs) between January and December 2022.
65. There were three ways that the Registrant admitted he was involved in the Online Prescribing Service:
- a. Completing customs declaration labels;
 - b. Completing labels for the dispensed medication against private prescriptions sent by the Online Prescribing Service; and
 - c. Actually dispensing some medication against private prescriptions as part of the Online Prescribing Service.
66. As regards (a) above, the Registrant admitted to Ms 1, at the 20 December 2022 inspection, that he had completed customs declaration labels to indicate that the packages contained "health supplements" despite their contents being prescription-only medication and controlled drugs. Ms 1's evidence was that the Registrant told her that he had been told to complete the labels in this way by HealthInfoServices. In his witness statement which he adopted in oral evidence, the Registrant stated that HP had occasionally asked him to help him with completing customs declarations. He asked HP why the labels said "health supplements" instead of medicines and was told there was an issue with theft by the courier/postal service when the declarations stated "medicines" so there was a generic description of the products to reduce the risk of theft. It never occurred to the Registrant that this labelling may have meant it was less likely the packages would be stopped by US customs nor was this ever mentioned to him.

67. As regards (b) above, the Registrant admitted in his witness statement that HP occasionally asked him to print out dispensing labels for him for the Online Prescribing Service.
68. As regards (c) above, in oral evidence, in answering questions both in cross-examination and from the Committee, the Registrant also admitted to occasionally dispensing drugs for the Online Prescribing Service.
69. The Committee also considered that the nature of the Online Prescribing Service was an important factor in deciding what steps the Registrant should have taken when carrying out the above roles. There were two key elements that should have led the Registrant to question the safety and legality of the Online Prescribing Service: the need to input false data on customs declaration labels and the fact that prescriptions were written by doctors in the EEA for patients all over the world and principally the USA. The Registrant admitted in evidence that when he was involved in dispensing medication for the Online Prescribing Service, he did so against prescription documentation. The Committee had sight of several examples of such documentation, albeit not necessarily the exact documentation seen by the Registrant. All showed patients who were registered in countries different from the prescriber and all showed the prescriber to be based in Bulgaria. Indeed, Document 2, the spreadsheet of the prescription records, showed an enormous number of prescriptions to be written by the same prescriber.
70. The Committee considered that these issues of which the Registrant was aware should have been enough for him to take steps to ensure the safe and legal supply of the medication. The Registrant admitted in evidence that the above did “raise alarm bells”. He said he asked HP about it who told him that consultations were done with GPs who did then prescribe the medication. However, he made no further enquiries with HP “possibly because I had the belief he knew what he was doing and I didn’t want to interfere as opposed to waiting for him to tell me which wasn’t right”. The Committee did not feel that asking one question was sufficient for the Registrant to discharge his duties as a registered pharmacist and certainly not as the RP on the 19

occasions on which he acted as RP and the Online Prescribing Service was operating and medication was supplied to patients.

71. The Committee was therefore satisfied on the balance of probabilities that the Registrant did not take steps or effective steps to ensure that the Online Prescribing Service was conducted safely and/or legally. Accordingly, the Committee went on to consider the sub particulars of the allegation and considered that the way in which the allegations were drafted was that the sub particulars were seen as examples of the effective steps the Registrant should have taken to ensure the Online Prescribing Service was conducted safely and/or legally. The Committee therefore considered the Registrant's duty in respect of each sub particular.

Allegation 4.1

4.1 The medicines supplied by the Pharmacy included:

4.1.1 Opioid-based painkillers

4.1.2 Benzodiazepines

4.1.3 Sleeping tablets

72. No issue was taken by the parties that the online supplies included the above and indeed Document 2 set out the supply of the above between January and December 2022.

This particular is found proved.

Allegation 4.2

4.2 Audits were not carried out to determine the suitability of the prescribing to verify the safety and quality of the dispensing service.

73. The Committee heard and accepted the evidence of Ms 1 that the Pharmacy had not carried out any audits to determine the suitability of the prescribing or analyse the prescribing habits which could help verify the safety and quality of the service being provided.
74. The Committee was satisfied that the Registrant should certainly have made enquiries of HP or others to ascertain what audits were being carried out. The Registrant could not have ensured the safety of the online supplies (when dispensing as a second pharmacist, filling out customs declaration and when RP) without making those enquiries. On his own admission, he took no steps to check this, he simply carried out his role on instruction without sufficiently questioning the safety and legality of his actions. Accordingly, the Committee was satisfied there was a duty and Registrant did not discharge it.

This particular is found proved.

Allegation 4.3

4.2 There were no records to justify why prescriptions were issued and dispensed.

75. The Committee heard and accepted the evidence of Ms 1 that HP was unaware whether the prescribers ever contacted people as part of the consultation process. Further, according to her, there were no records or notes to show justification for prescribing or why prescriptions had been issued without consulting the person's regular GP.
76. The Committee was satisfied that the Registrant should certainly have made enquiries as to why medication had been prescribed. The Committee saw no evidence that the Pharmacy had access to documentation justifying prescriptions such as summary care records or equivalent. The Registrant could not have ensured the safety of the online supplies (when dispensing as a second pharmacist, filling out customs declaration and when RP) without making those enquiries. On his own

admission, he took no steps to check this, he simply carried out his role on instruction without sufficiently questioning the safety and legality of his actions. Accordingly, the Committee was satisfied there was a duty and Registrant did not discharge it.

This particular is found proved.

Allegation 4.4

4.4 On inspection on 20 December 2022, there was no information to show how patient's identification was checked.

77. The Committee heard and accepted the evidence of Ms 1 that there was no information provided on how people's ID was checked during her inspection on 20 December 2022. This particular finding was not set out in Ms 1's notebook but it was set out in the notice of conditions dated 23 December 2022, some 3 days after the visit. Further, Ms 1 in oral evidence stated that there was no communication with patients throughout the Online Prescribing Service.
78. The Registrant showed a good understanding when giving evidence about how to undertake an effective identification check for supply of medication in the community pharmacy context. The Registrant had taken no such steps for the online supplies and he was under a duty to make enquiries about this before he played an active role in the operation. The Registrant could not have ensured the safety of the online supplies (when dispensing as a second pharmacist, filling out customs declaration and when RP) without making those enquiries. On his own admission, he took no steps to check this, he simply carried out his role on instruction without sufficiently questioning the safety and legality of his actions. Accordingly, the Committee was satisfied there was a duty and Registrant did not discharge it.
79. Mr McCartney submitted that identification checks were covered in the SOP provided on 10 March 2023 by the Registrant. He relied on the safeguarding section

of the SOP. However, the Committee considered that this section of the SOP did not in fact cover identification checks for the *delivery* of medication. The SOP in fact purported to cover the checking of the capacity of clients to order medication.

This particular is found proved.

Allegation 4.5

4.5 There were no written risk assessments for medications and treatments dispensed and supplied.

80. The Committee heard and accepted the evidence of Ms 1 that the Pharmacy had not completed any risk assessments prior to initiating or throughout the course of providing this service. In addition, in his letter through his legal representatives dated 10 March 2023, the Registrant responded to a request from the Council for such risk assessments. His letter stated: “Mr Bhagat has been unable to locate any additional risk assessments in relation to overseas dispensing and prescribing. As stated above, this was not something that he had any direct involvement in, either when working occasionally as Responsible Pharmacist in Lords Dispensing Chemist or, since January 2023, as Superintendent Pharmacist.”
81. The Committee was therefore satisfied that there were no risk assessments. Equally, the Registrant should certainly have made enquiries about this. The Registrant could not have ensured the safety of the online supplies (when dispensing as a second pharmacist, filling out customs declaration and when RP) without making those enquiries. On his own admission, he took no steps to check this, he simply carried out his role on instruction without sufficiently questioning the safety and legality of his actions. Accordingly, the Committee was satisfied there was a duty and Registrant did not discharge it.

This particular is found proved.

Allegation 4.6

4.6 On inspection on 20 December 2022, there was no information to show how patients were safeguarded against the medications which were highly addictive.

82. The Committee heard and accepted the evidence of Ms 1 that:
- a. She carried out further analysis of the prescription data which identified several examples of people obtaining repeated supplies of significant quantities of medicines over the years and sometimes within a short period of time. There was no fixed interval between supplies being made and it was seen that large quantities were being sent in one order.
 - b. There were no steps in place to address the risk of potential abuse and no evidence to show how patients taking these medicines were being safeguarded.
83. The Committee was satisfied that the Registrant should certainly have made enquiries about the above. The Registrant could not have ensured the safety of the online supplies (when dispensing as a second pharmacist, filling out customs declaration and when RP) without making those enquiries. On his own admission, he took no steps to check this, he simply carried out his role on instruction without sufficiently questioning the safety and legality of his actions. Accordingly, the Committee was satisfied there was a duty and Registrant did not discharge it.

This particular is found proved.

Allegation 4.7

4.7 There were no specific Standard Operating Procedures in place for the dispensing service provided.

84. The evidence that there was no specific SOP came entirely from Ms 1. She stated in her witness statement that that there were no specific SOPs in place to support the

services the Pharmacy provided in association with the Online Prescribing Service. This was supported by her contemporaneous notebook which stated “no SOPs” and also by the notices to impose conditions on the Pharmacy. Furthermore and notably, by the time of the notice dated 13 January 2023, no SOP had been furnished on Ms 1 by the Pharmacy. In her evidence, Ms 1 stated that the imposition of conditions was serious and she would not have taken enforcement action if she thought more documents were available.

85. The Registrant relied principally on the fact that a detailed 12-page SOP was provided by him in his letter dated 10 March 2023.
86. On balance, the Committee accepted the evidence of Ms 1. If an SOP had been in place between January and December 2022, it would have been furnished on Ms 1 or the Council on either of Ms 1’s inspections or shortly thereafter.
87. The Registrant’s evidence was that he was unaware about the SOP until it was provided to him by HP in March 2023, shortly before he passed it on to the Council. The Committee considered that the Registrant was under a duty, particularly when acting as RP, to have ensured an SOP was in place for the Online Prescribing Service throughout 2022.

This particular is found proved.

Allegation 4.8

4.8 There was no service agreement to define the relationship and terms between the pharmacy and the prescribing service.

88. The evidence that there was no service agreement again came entirely from Ms 1. She stated in her witness statement that that there was no service agreement to define the relationship and terms between the pharmacy and the prescribing

service. Ms 1's contemporaneous notebook entry said as follows: "hasn't in his possession got a contract or SLA".

89. The Committee considered Mr McCartney's submissions about Ms 1's evidence generally. As set out above, he submitted that her evidence was based on her recollection of a conversation with HP. Further, her assertion that there was no service level agreement between the Pharmacy and HealthInfoServices was undermined by her contemporaneous notebook that stated "hasn't in his possession got a contract or SLA". Further, her claim that there were no private prescription records was undermined by the fact that she assisted the Registrant to obtain the data that made up Exhibit 2. Ms 1 sought to explain this discrepancy by stating that the detail of the private records was not legally compliant. Mr McCartney submitted that this undermined the credibility and reliability of her evidence generally.
90. The Committee was of the view that Ms 1 was on the whole a reliable witness and placed weight not only on her witness statement but the notices to impose conditions, a document that she considered to be serious. On the whole her findings were consistent with the evidence made available to her at the time but the Committee analysed the sufficiency of the evidence in respect of each sub-particular carefully.
91. Ultimately, the Committee was not satisfied that the Council had discharged the burden in proving that there was no service agreement at the time as opposed to merely not being in the Pharmacy's possession on the date of Ms 1's visit. Ms 1 did not have a recollection of her conversation about this issue independent from her contemporaneous notes and the notes themselves were somewhat ambiguous.

This particular is found not proved.

Allegation 4.10

4.10 Adequate insurance was not in place to cover the supply of medication to patients in the USA.

92. The Committee was satisfied that there was no adequate insurance for such supply. Ms 1's witness statement stated that "I was told that the pharmacy had not informed their indemnity insurers of the dispensing service they were providing for the prescribing service. The pharmacy did not have adequate indemnity insurance cover to supply medicines to people living in the USA or Canada." Furthermore, none of the insurance documentation supplied by the Registrant on 10 March 2023 covered the supply of medication to patients in the USA.
93. However, the Committee was not satisfied that the issue of insurance was something that the Registrant had a duty to explore as either RP or second pharmacist. The insurance was a matter squarely within the purview of an SI or owner and the Council had not proved that the duty to ensure this rested with the Registrant.

This particular is found not proved.

Allegation 4.11

4.11 The Pharmacy had no export licence.

94. The Committee was satisfied that the Pharmacy held no such licences as the unchallenged evidence of Mr 3 (Head of Firearms & Import/Export Drugs Licensing at the Home Office) was that the Pharmacy held no MHRA licences.
95. Unlike the position regarding indemnity cover, however, the Committee considered that an appropriate licence was something that ought to have occurred to the Registrant once he became aware that prescription-only medications and CDs were being supplied to the USA. His own evidence was that dispensing medication to the USA rang "alarm bells" and, as such, the Committee found that he did have a duty to explore the legality of the supply of prescription-only medications and CDs to the

USA. This should have triggered him to question whether the Pharmacy held the appropriate licence, either as RP or second pharmacist.

This particular is found proved.

Allegation 6

6 Your actions at 5 above were dishonest in that you knew that some of the packages contained controlled drugs and that “health supplements” was an inaccurate and misleading description of the contents.

96. The Committee bore in mind the following test from Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 67:

- a. “When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual’s knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. [...]”
- b. “Once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.”

97. The Committee therefore first ascertained the Registrant’s actual state of knowledge of belief as to the facts. As set out above, the Registrant’s position on this allegation was as follows. He admitted to Ms 1 on the 20 December 2022 inspection that he had completed customs declaration labels to indicate that the packages contained “health supplements” despite their contents being prescription-only medication and

CDs. Ms 1's evidence was that the Registrant told her that he had been told to complete the labels in this way by HealthInfoServices.

98. In his witness statement which he adopted in oral evidence, the Registrant stated that HP had occasionally asked him to help him with completing customs declarations. He asked HP why the labels said "health supplements" instead of medicines and was told there was an issue with theft by the courier/postal service when the declarations stated "medicines" so there was a generic description of the products to reduce the risk of theft. It never occurred to the Registrant that this labelling may have meant it was less likely the packages would be stopped by US customs nor was this ever mentioned to him.
99. The Committee was satisfied of the following:
- a. The Registrant knew "health supplements" to be inaccurate;
 - b. The Registrant knew that this was potentially misleading for whomever looked at a package with such a label without knowledge of the contents;
 - c. The Registrant had concerns about this because the labelling in this manner led to his asking HP why the labels were being filled in in this manner;
 - d. HP's response was that this was to reduce the risk of theft.
100. Despite the above, the Committee was satisfied that the Registrant essentially turned a blind eye to the concerns and relied on the excuse provided to him by HP. The Committee felt that the excuse provided did not make sense because if such labelling was sufficient to mislead a potential thief, it would be sufficient to mislead the very people relying on the accuracy of a declaration on a customs label i.e. customs officers. There is a significant difference between health supplements and medication. A difference that is particularly apparent to a pharmacist. Any belief that there was a legitimate reason to mislabel the packages would not be reasonable. The Committee considered that to be determinative of the Registrant's actual state of mind. The Registrant was aware that he was making a false declaration without good reason.

101. Due to the above, the Committee was quite satisfied that the conduct was dishonest by the standards of ordinary decent people. The honest thing to have done would have been to refuse to make such declarations on being given unsatisfactory answers by HP.
102. The Committee did not go on to consider allegation 7 as it was an alternative to allegation 6.

This particular is found proved.

Allegation 8

8 On 20 December 2022, did not ensure that controlled drugs, including methadone, were stored securely in accordance with The Misuse of Drugs (Safe Custody) Regulations 1973.

103. Ms 1 provided the following evidence in her witness statement. “CDs were not stored securely. The pharmacy had two CD cabinets both were blocked with items placed in front of them. A large volume of expired and patient returned CDs as well as methadone was found to be stored under the workbench in the dispensary.” Multiple photographs were also exhibited by her showing the haphazard way in which the drugs were spread around the dispensary. At the conclusion of the evidence, it appeared that all of the CDs which were not in the cabinet were in the office located within the dispensary.
104. As stated above, this allegation turns on the definition of “stored securely in accordance with The Misuse of Drugs (Safe Custody) Regulations 1973” and the following relevant extracts of regulation 3:

[...] the occupier and every person concerned in the management of any premises to which this Regulation applies shall ensure that all controlled drugs (other than those specified in Schedule 1 to these Regulations) on the premises are, so far as circumstances permit, kept in a locked safe, cabinet or

room which is so constructed and maintained as to prevent unauthorised access to the drugs.

It shall not be necessary to comply with the requirements of paragraph (2) of this Regulation in respect of any controlled drug which is for the time being under the direct personal supervision of—

[...] (a) a pharmacist

105. The Registrant's evidence is that he was dealing with dispensing of NHS medication at the time of Ms 1's visit and that HP was in the dispensary office undertaking a stock take. The CDs were accordingly under HP's direct personal supervision. The Council could not present any evidence that the CDs were outside of the cabinet for a longer period than that claimed by the Registrant or indeed that he was even aware of the CDs being outside of the cabinet. Accordingly, the Council could not discharge the burden of proof in respect of allegation 8.

This particular is found not proved.

Misconduct and Impairment

106. Having found some particulars of allegation proved, the Committee went on to consider whether the particulars found proved amounted to misconduct and, if so, whether the Registrant's fitness to practise is currently impaired.
107. The Committee took account of the guidance given to the meaning of 'fitness to practise' in the Council's publication *"Good decision-making"* (Revised March 2024). Paragraph 2.12 reads:

"A pharmacy professional is 'fit to practise' when they have the skills, knowledge, character, behaviour and health needed to work as a pharmacist...safely and effectively. In practical terms, this means maintaining

appropriate standards of competence, demonstrating good character, and also adhering to the principles of good practice set out in our various standards, guidance and advice.”

108. The Committee took into account the submissions made by the Case Presenter and by Mr McCartney.
109. The Case Presenter submitted as follows:
 - a. Misconduct was not in question – the Registrant was conscious at least of the sorts of risks that might be engaged and turned a blind eye to the scale of what was going on and therefore to those consequences. He had all the requisite knowledge to know the standards were engaged.
 - b. The Online Prescribing Operation plainly brought the profession into disrepute. The Registrant’s specific role also engaged this because the expectation of the public at large is that pharmacists exercise judgement and leadership and it is not enough to abdicate one’s professional responsibility.
 - c. The finding of dishonesty in the instant case is not necessarily of the most serious kind. Despite this, the wilful blindness to consequences does breach one of the fundamental principles, namely honesty.
 - d. As regards insight and remediation, there is a gulf between the concessions sensibly made in the Registrant’s reflective piece and the real insight required in this case.
110. Mr McCartney helpfully indicated that the Registrant saw that misconduct was a likely conclusion given the Committee’s findings. Further, a finding of impairment was seen as almost entirely inevitable. Mr McCartney focussed his submissions on the basis of the finding of impairment as follows:
 - a. The Registrant had worked for a considerable period of time under HP (in total 13 years) as a pharmacy technician and then qualifying as a registered pharmacist at the end of 2021. This was also a time where the Registrant was juggling personal responsibilities, including caring for a young family.
 - b. The Registrant’s primary role was as an NHS community pharmacist and had limited involvement in the Online Prescribing Service. That inexperience was mitigation even if it did not wholly absolve the Registrant of responsibility.

- c. This was a case at the lower end of the spectrum of dishonesty as it involved turning a blind eye instead of saying no to a more senior colleague when asked to do a task.
- d. The five positive character references dated in 2025 showed that this was conduct that was out of character.
- e. Although the behaviour presented a potential risk in the past, there was no evidence of any risk for the past three years. The Registrant had taken over as SI pharmacist in March 2023 and had practised without restriction. It should be noted that the Pharmacy remains under conditions that prevents it from supplying medication issued by online prescribing services and those not based in the UK. Further, there is a restriction that prevents it from handling Schedule 2 and 3 CDs.
- f. There is not a risk that the Registrant's behaviour would bring the profession into disrepute in the future or that his integrity could no longer be relied upon going forward.
- g. The Registrant had undertaken impressive reflection and remediation which included familiarising himself with GPhC guidance, undertaking a Centre for Pharmacy Postgraduate Education ("CPPE") CD management course and completing a pharmacist independent prescribing course.
- h. This case was a good example of the proceedings themselves achieving a regulatory objective in that the Registrant's practice had been strengthened.
- i. There was both personal and public insight in that the Registrant showed insight into how he personally had failed but also the impact his failings would have on public confidence in the profession.

111. The parties also made submissions to the Committee about Sawati v GMC [2022] EWHC 283 (Admin) regarding the use the Committee could make of a rejected defence at this stage in proceedings.

Decision on misconduct.

112. When considering whether the particulars found proved amounted to misconduct the Committee took into account the *Good Decision making guidance/Fitness to Practice hearings and Outcomes Guidance 2024* (The Guidance).
113. The Committee considered whether the Registrant had breached any of the Council's Standards for Pharmacy Professionals (May 2017). The Committee determined that there had been breaches of the following Standards:
- a. Standard I: to provide person centred care;
 - b. Standard V, to exercise professional judgement;
 - c. Standard VI, to behave in a professional manner;
 - d. Standard VIII, to speak up when they have concerns or when things go wrong;
 - e. Standard IX, to demonstrate leadership.
114. The Committee bore in mind that the Standards may be taken into account when considering the issues of grounds and impairment but that a breach of the Standards does not automatically result in a finding of misconduct (Rule 24(11) of the Rules).
115. The Committee concluded that the Registrant was involved in the regular supply of CDs abroad without any of the requisite safeguards in place. He turned a blind eye to the issues surrounding the Online Prescribing Service and failed to exercise professional judgement and speak up when he had concerns. Furthermore, the Registrant inputted false data on customs declaration labels in a dishonest manner. These were clearly breaches of the Standards and were serious departures from what is expected of registrants.
116. Accordingly, the Committee concluded that, in its judgement, the Registrant's acts and omissions amounted to misconduct.
117. The Committee therefore went on to consider whether the Registrant's fitness to practise is impaired.

Decision on Impairment

118. Having found that the particulars of allegation amounted to misconduct, the Committee went on to consider whether the Registrant's fitness to practise is currently impaired. In doing so the Committee considered whether the particulars found proved show that actions / omissions of the Registrant:

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

119. The Committee also considered 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; and*
- *a finding of impairment is needed to declare and uphold proper standards of behaviour and/or maintain public confidence in the profession.*

Public Protection

120. The Committee was in no doubt that the actions of the Registrant in assisting with the Online Prescribing Service in 2022 had the real potential to put patients at risk. CDs were continuously supplied without appropriate safeguards in place to ensure the right people received them for the right reasons and that they were not abused given their highly addictive nature. The supply of drugs in this manner, with flaws throughout the process, breached the fundamental tenet of the profession to practise safe and effective care.

121. However, in considering current impairment, the Committee was mindful that there had been no risk to the public from the Registrant's practice for over three years and that the Registrant had been working as an SI pharmacist in that time.

122. The Registrant had also shown what the Committee considered to be an impressive level of insight into his actions, particularly as regards his lack of integrity, in the following extract from the reflection section of his witness statement:

This has been a difficult but important realisation for me, that accountability is not removed by hierarchy. Even when the instruction comes from a supervisor, it is still my responsibility to ensure compliance with professional standards. Following instructions without challenge does not constitute safe practice. This experience has strengthened my ability to question instructions that conflict with GPhC standards, SOPs, Medicines legislation as well as good clinical practice. I now appreciate the importance of respectfully challenging unsafe or unclear instructions.

123. In terms of any ongoing risk, the Committee was mindful of the context in which these allegations arose, namely that the Registrant had just qualified as a pharmacist and was asked to assist with tasks by his mentor, HP, to whom he owed a lot given his lengthy employment by him from 2009 to 2022. That context had now been removed from the Registrant's practice and he has not posed a risk to the public for three years.
124. It should also be borne in mind that the restrictions on the Pharmacy's practice by way of conditions have removed some of the risks to patient safety. Notwithstanding that the Registrant is not dispensing Schedule 2 and 3 CDs at the Pharmacy currently, the Committee noted the significant learning by way of the CPPE and PIP courses which has strengthened his knowledge of the rules, governance and rigorous safety measures involved in online prescribing, such that it was satisfied that were the Registrant to practise in another Pharmacy with no conditions in place, he would no longer pose a risk to patient safety. The Committee was satisfied that the conduct has been addressed and is unlikely to be repeated. For those reasons, the Committee determined that the Registrant no longer poses a risk to patients or the public and a finding of current impairment was not required on the ground of public protection.

The Public Interest

125. Again, the Committee was in no doubt that the actions of the Registrant brought the profession into disrepute and breached fundamental tenets of the profession. The integrity of the Registrant at the time could clearly not be relied upon either.
126. Well-informed members of the public expect pharmacists to carry out their roles safely and professionally. Pharmacists are expected to exercise judgement and leadership and call out mistakes and unsafe practices, not abdicate their responsibilities. The public expect medication supplied to them to be safe and for proper processes to be followed.
127. The public also expect a higher standard of integrity from registered professionals and certainty that they will not act dishonestly. To behave in a dishonest manner brings the profession of pharmacy into disrepute and breaches fundamental tenets of the profession, namely to practise professionally and demonstrate leadership.
128. The Committee considered that the dishonest behaviour displayed by the Registrant in 2022 showed an attitudinal issue that was more difficult to put right than some other concerns. Although the Committee felt that significant steps had been taken to address the conduct, which was out of character for the Registrant, dishonesty is a serious matter notwithstanding that, in this case, it falls at the lower end of the spectrum.
129. Taking all of the evidence before it into account, the Committee is satisfied that members of the public, if they were fully appraised of the facts of this case, would be shocked to learn that the Registrant has behaved in the manner found proved, and would expect the regulator to make a finding of impairment in the wider public interest, in order to send a message to the public and the profession, as to the standards of practice which the regulator expects to be observed by registered pharmacists and deterring other professionals from failing to meet standards.

130. The Committee therefore finds the Registrant's current fitness to practise to be impaired on public interest grounds and accordingly went on to consider the issue of outcome.

Decision on Outcome

131. Having found impairment, the Committee has gone on to consider the matter of outcome. The Committee's powers are set out in Article 54(2) of the Order. The Committee should consider the available outcomes in ascending order from least restrictive, take no action, to most restrictive, removal from the Register, in order to identify the appropriate and proportionate outcome that meets the circumstances of the case.
132. The purpose of the outcome is not to be punitive, though an outcome may in fact have a punitive effect. The purpose of the outcome is to meet the overarching objectives of regulation, namely the protection of the public, the maintenance of public confidence and to promote professional standards. The Committee is therefore entitled to give greater weight to the public interest over the Registrant's interests.
133. The Committee had regard to the Council's '*Good decision making: Fitness to practise hearings and outcomes guidance*' to inform its decision.
134. The Committee took into account the submissions made by the Case Presenter and Mr McCartney. The Committee also received a supplementary witness statement signed by the Registrant and dated 3 September 2026. Exhibited within that statement was evidence of the Registrant's keeping up to date with CPD and confirming that he had completed a Leadership Development Programme as part of a cohort of 20 community pharmacist Primary Care Network leads from different neighbourhoods. The statement further confirmed that the Registrant stood down from his role as superintendent pharmacist in June 2026. He had continued to work as a full-time RP and pharmacy manager since that date.

135. The Case Presenter submitted that a suspension towards the top end of the 12 month maximum was an appropriate outcome in this case. This was a serious case where the Registrant lent himself repeatedly to a particularly dangerous and harmful enterprise and was wilfully blind to the role he played therein. That being said, the Registrant had also shown insight, and he played a relatively limited role under the direction of his mentor. Given the seriousness of the Registrant's conduct, a warning was insufficient in a case such as this. This was not a case where appropriate conditions could be formulated but removal from the register was not appropriate as this was not one of the "most serious cases" before the Regulator.
136. Mr McCartney responded as follows:
- a. It was important not to conflate the Registrant's overall failure to act in relation to the Online Prescribing Service with the discrete dishonesty that related only to the completion of customs declaration labels;
 - b. The finding of impairment is in itself an important part of the regulatory process in marking disapproval of the actions found proved;
 - c. The dishonesty was at the lower end of the spectrum and arose out of unique circumstances and a unique relationship with his mentor;
 - d. There was a public interest in keeping an effective and passionate practitioner with enhanced qualifications in practice;
 - e. Public confidence could be maintained by the imposition of a warning as the public interest did not *demand* suspension as set out in the Council's Guidance;
 - f. If suspension were deemed appropriate, it should be for a short period given the Registrant's conduct for the past four years and other mitigation;
 - g. A review would not be appropriate in a case such as this, where there has been effective remediation and insight.
137. The Committee first considered what, if any, aggravating and mitigating factors there may be.
138. The Committee identified the following aggravating factors:
- a. The duration of the Registrant's involvement from January to December 2022;
 - b. The quantity of medication supplied by the Online Prescribing Service;

- c. The repetition of the Registrant's conduct;
- d. Failing to raise concerns, including when working as RP; and
- e. The significant risk of harm to patients and members of the public given the lack of safeguards involved in the Online Prescribing Service.

139. The Committee identified the following mitigating factors:

- a. The Registrant had recently qualified at the time of his involvement;
- b. The fact his involvement was relatively limited as the Online Prescribing Service was being run by HP who was SI at the time;
- c. The power dynamic between the Registrant and his long-term mentor, HP, for whom the Registrant had worked for 13 years prior to 2022 as a pharmacy technician;
- d. The Registrant did not gain financially from his involvement;
- e. The Registrant's insight and remediation;
- f. The lack of repetition of any misconduct over the past four years; and
- g. Positive testimonials and CPD.

140. To take no action: The Committee did not deem this case to be appropriate for no action to be taken as this was a case involving dishonesty and repeated involvement in an operation that represented a serious departure from the standards.

141. Warning: The Committee gave this outcome serious consideration. The Council's guidance states that this outcome may apply where:

There is a need to demonstrate to a professional, and more widely to the profession and the public, that the conduct or behaviour fell below acceptable standards.

There is no need to take action to restrict a professional's right to practise, there is no continuing risk to patients or the public, but there needs to be a public acknowledgement that the conduct was unacceptable.

142. The Committee agreed with Mr McCartney that this outcome was potentially appropriate given its finding that there was no continuing risk to patients or the public. Further, the Committee was of the view that the public interest required a public acknowledgement that the Registrant's conduct was unacceptable. However, this case concerned the Online Prescribing Service that involved serious risks to the public that should have been obvious to any pharmacist, not least one who would recently have learnt about the standards as part of their education. Becoming involved in such an operation was a serious departure from the judgement required from registered pharmacists. Although the dishonesty findings of the Committee were limited to completion of customs declaration labels under direction, the turning of a blind eye in this manner was again a serious failing from the Registrant. Given the seriousness of the case, the Committee did not feel that a warning sufficiently reflected the manner in which the Registrant's conduct fell below acceptable standards. The Committee considered that a well-informed member of the public would not feel that the regulator had grasped the seriousness of the dangers of the Online Prescribing Service and the importance of pharmacists acting with honesty and integrity by imposing a warning.
143. Conditions of Registration: The Committee next considered the imposition of conditions of registration. A Conditions of Registration Order would allow the Registrant to practise albeit with restrictions. The Committee must determine whether a Conditions of Registration Order would be appropriate given the concerns identified regarding the Registrant's practice, in particular whether conditions would protect the public from harm, be sufficient to mark the seriousness of the matter so as to maintain public confidence in the Registrant, the profession and the Regulator, and sufficient to promote professional standards within the profession.
144. If conditions are to be imposed, the conditions must be relevant and proportionate to the concerns identified regarding the Registrant's practice. Conditions must be workable and susceptible to being monitored. The Committee must also be satisfied that the Registrant will comply with any conditions imposed.
145. The Committee agreed with the submissions of both parties that in a case where it was only on public interest grounds that the Registrant's fitness to practise was

impaired, conditions are difficult to formulate and unlikely to address the Committee's concerns. The Committee had already made a finding that there was no continuing risk to patients and the Registrant's practice and insight was not such as needed to be supervised by conditions.

146. Suspension Order: The Committee next considered whether suspension would be a proportionate outcome. The Committee noted the Council's guidance which indicates that suspension may be appropriate where:

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

147. Having considered that a warning would be insufficient to uphold public confidence and proper standards, the Committee concluded that this was a case where the public interest demanded no lesser sanction than suspension. A period of suspension is an appropriate and proportionate outcome to send a clear message to professionals and to the public that the Regulator takes the Registrant's dishonesty and involvement in the dangerous Online Prescribing Service extremely seriously. This will ensure that the public can continue to have confidence in the profession and will uphold professional standards and maintain the public's confidence in the Regulator itself.
148. In making this decision, the Committee considered the impact of suspension on the Registrant personally. The Registrant's supplementary witness statement outlined how he is the main breadwinner for his family and any period of suspension would have an immediate impact on his household. The Committee was equally mindful of the impact of the Registrant's actions on the reputation of the profession. Given the seriousness of the actions of the Registrant, the Committee gave greater weight to the public interest than the consequences for the Registrant, even if a period of suspension might have a punitive effect.

149. As regards the length of suspension, the Committee took into account all of the aggravating and mitigating factors. The Committee agreed with Mr McCartney's submission that if suspension were imposed, it should be for a relatively short period of time given the mitigating factors, not least the Registrant's conduct since 2022. The Committee also considered the competing public interest of an otherwise competent pharmacist being able to continue to serve his community and the wider public. The Committee decided that a period of suspension for three months was appropriate and proportionate in the circumstances.
150. Having concluded that an order of suspension was likely to be sufficient and proportionate in all the circumstances of the case, the Committee briefly turned to consider whether this was a case in which the most serious outcome, that of removal, was appropriate. The Good decision making Guidance states that removal is "reserved for the most serious conduct" and that it should be considered "when the registrant's behaviour is fundamentally incompatible with being a registered professional". The Committee concluded that removal would be disproportionate given the mitigating factors identified above and the Registrant's good practice for the past four years.
151. The Committee therefore directs that the Registrar suspends the Registrant's entry in the Register for a period of three months.

Review Hearing

152. The Committee did not consider a review to be necessary in this case given the insight and remediation already undertaken by the Registrant and the low likelihood of any further breaches of the Standards.

Decision on Interim Measure

153. No application was made by the Council for an interim measure and therefore the Committee did not go on to consider whether one was necessary to cover the 28 day appeal period.

154. This concludes the determination.