

General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote videolink hearing

2-6 March, 5-6 May, 22 May, 15-17 September 2026

Registrant name: Raju Kanti Patel

Registration number: 2062020

Part of the register: Pharmacist

Type of Case: Misconduct

Committee Members: Neil Calvert (Chair)

Cristian Ioanas (Registrant member)

Stephanie Hayle (Lay member)

Legal Adviser: Michael Levy - Counsel

Clinical Adviser: Dr Sabarigirivasan Muthukrishnan (Stage 1 only)

Committee Secretary: Mark Mallinson (2 March)

Adam Hern (3-6 March)

Ivana Raimundova (5-6 May, 22 May, 15-17
September)

Registrant:	Present and represented by Anthony Haycroft, Counsel
General Pharmaceutical Council:	Represented by Simeon Wallis – Counsel - Case Presenter
Facts proved:	1, 2 – only in respect to Oramorph/morphine sulphate, 4(b) and (h), 8(b) and (e), 9
Facts proved by admission:	6(l), 7 in respect of 6(l) only and 8(a)
Facts not proved:	3, 4(a), (c), (d), (e), (f) and (g), 5, 6(a)-(k), 8(c) and (d)
Fitness to practise:	Impaired
Outcome:	Suspension 4 months without review

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

Particulars of Allegations:

You, a registered Pharmacist, while part-owner, Superintendent and often responsible Pharmacist of Harper's Pharmacy, Brighton ("the Pharmacy"):

1. On one or more occasion(s) between 1 January 2018 and 25th August 2018, substituted or caused or allowed the following medicine(s) to be substituted with water or another Liquid including water:
 - (a) Oramorph/ Morphine Sulphate, and/or
 - (b) Oxycodone hydrochloride.
2. On one or more occasions between 1 January 2018 and 25 August 2018, supplied or caused or allowed a quantity of the liquid or liquids referred to at 1 above. To be supplied to Patient A when she was expecting to receive Oramorph.
3. Your conduct in 2 above was dishonest in that:
 - a. You knew that Patient A was prescribed Oramorph
 - b. Knew that the bottle dispensed did not contain Oramorph
 - c. Represented to Patient A that it contained Oramorph
4. On a date in August 2018, when visiting Patient A at home, you behaved in a manner that you knew or ought to have known would cause alarm and distress to Patient A in that:
 - (a) The visit was late at night
 - (b) Patient A was in her own home
 - (c) Patient A told you that you could not come in
 - (d) You barged past the door that Patient A was holding
 - (e) Your action at (d) above caused Patient A pain
 - (f) You were alone in the porch with Patient A
 - (g) You told Patient A to drink medication you opened in front of her, even though she had refused; and/or

- (h) You asked the patient to give you the container reported to contain a water-like substance;
5. On 25th August 2018, had all or any of the following controlled drugs and/or prescription only medications at your home without good reason:
- (a) 8 x Tamazepan tablets;
 - (b) 500ml Oramorph 10mg/5ml;
 - (c) 7 x Buprenorphine tablets;
 - (d) 1 x Methylphenidate tablet;
 - (e) 15 x Lisdexamphetamine tablets
6. On 25th August 2018, had all or any of the following controlled drugs registers at your home without good reason:
- (a) Diamorphine 30mg amp;
 - (b) Morphgesic SR 10mg m/r tablets;
 - (c) MST Continus 5mg m/r tablets;
 - (d) MST Continus 10mg tablets;
 - (e) MST Continus 15mg tablets;
 - (f) MST Continus 60 mg tablets;
 - (g) MST Continus 100mg tablets;
 - (h) Diamorphine 5mg injection;
 - (i) Diamorphine 10mg powder solution;
 - (j) Physeptone 5mg tablets;
 - (k) Morphgesic 30mg m/r tablets.
 - (l) Physeptone 1 mg/1ml Sugar Free
7. Your conduct in 6 above breached patient confidentiality.
8. Between January 2018 and August 2018 on one of more occasion(s) you consumed the following:

- a) Morphine and/or
- b) Oxycodone and/or
- c) Cocaine and/or
- d) Narcocaine [sic] and/or
- e) Amphetamine

9. Between January and August 2018 failed to keep up to date Responsible Pharmacist Logs.

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

Documentation

Document 1- Council - Hearing bundle

Document 2- Council – Statement of Case/Skeleton Argument

Document 3- Agreed Facts

Document 4 – Defence Bundle

Document 5 – Defence Statement of Case

Document 6 – Defence Skeleton Argument

Document 7 – Defence Witness List

Document 8 – Defence Timeline of Case

Document 9 – Patient A Medication Record

Document 10 – Letter to HMP Isle of Wight

Document 11 – Telephone File Note

Document 12 – Previous statements of Patient A

Document 13 – Council email from police 4/3/26

Document 14 – Defence Submissions re adjournment

Document 15 – Council Submissions Stage 1

Document 16 – Defence Submissions Stage 1

Document 17 – Registrant’s bundle stage 2

Document 18 – Council Submissions Stage 2

Document 19 – Defence Submissions Stage 2

Document 20 – Council Submissions Stage 3

Document 21 – Defence Submissions Stage 3

Witnesses

Patient A - gave evidence at facts stage

MA - gave evidence at facts stage

LD - gave evidence at facts stage

The Registrant also gave evidence 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 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.

Conflict of Interests

6. None

Service of Notice of Hearing

7. The Committee has seen a letter dated 2 February 2026 from the Council headed 'Notice of Hearing' addressed to the Registrant and sent to their registered email address as noted on the Register. No issue was taken with service by either of the parties.
8. 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.
9. The Committee accepted the advice of the Legal Adviser

Registrant's response to Particulars of allegation

10. The Registrant admitted the following particulars:

6(l), 7 in respect of 6(l) only and 8(a)
11. In the light of the above, and by the application of Rule 31(6) of the Rules, the admitted factual particulars were found proved. The Committee noted the Registrant's partial admission of particular 9, but considered that it was not sufficient to allow it to find this particular proved in its entirety by the application of Rule 31(6).
12. The Committee went on to receive evidence and submissions regarding the remaining disputed particulars.

Council's Statement of Case

13. This Principal Hearing relates to Raju Kanti Patel ("the Registrant"), a pharmacist first registered with the General Pharmaceutical Council ("the Council") on 23 August 2005 with Registration No 2062020.

14. The various concerns about the Registrant came to light after Patient A reported the incident in August 2018 to the police. He was at that time the Superintendent Pharmacist of Harpers Pharmacy in Brighton. ("the Pharmacy").

Allegations 1 – 4

15. Patient A obtained Oramorph from the pharmacy to manage pain caused by a prolapsed disc. On the first of two occasions in January 2018 her carer MA collected an Oramorph bottle from the pharmacy. The bottle was sealed. When it was poured from the bottle both Patient A and MA noted that the smell and consistency were not like the Oramorph syrup both were familiar with. On tasting it, Patient A believed it was water. The Registrant delivered a replacement bottle and asked for the bottle to be returned on being told it was water, but Patient A told him she had thrown it away. In fact, she had retained it because of her concerns.
16. On the second occasion in August 2018 a bottle was delivered by the Pharmacy to Patient A's home. Patient A again thought it was water and said as such to the carer helping her on that day, LB. LB informed her employer (the Care Agency) who raised a concern with the Pharmacy and made notes.
17. On about 20 August 2018 the Registrant attended Patient A's house. She describes their interaction. In short, the Registrant behaved erratically, insisted on entering Patient A's property and barging past a door she was holding. He told her to drink a replacement medication he had brought and demanded the return of the original bottle. Patient A kept the bottle but again told him it had been disposed of. The Registrant appeared to be anxious.
18. The Care Agency reported this incident to the police on 24 August 2018.
19. Patient A gave an earlier witness statement to police in which she described this incident having taken place in June 2018 – this appears to be an error given the timing of the police report and LB's notes.

20. PCSO B seized the three bottles provided by the Registrant. The two which had contained the watery substance and the replacement bottle. Subsequent testing revealed that only one contained morphine. Morphine was not detected in the other two, but water was.

Police Investigation and Allegations 5 - 7

21. The Registrant was arrested on 25 August 2018. A police search of his home address uncovered multiple controlled drugs, including buprenorphine, methylphenidate, lisdexamfetamine, morphine sulphate, Oramorph and oxycodone preparations, together with controlled drug registers. Subsequent testing of two bottles labelled morphine seized from the Registrant's home confirmed that they contained water.
22. The Registrant gave a largely no-comment interview to police under caution asserting that he had supplied a different generic morphine product on one occasion, that one supply was an emergency supply, and denying reuse of containers. He was released on 26 August 2018.
23. On 30 August 2018, DC H and PC J conducted a search of the Pharmacy with a Drugs Liaison Officer. They noted that a bottle of oxycodone hydrochloride with a broken seal appeared to have no smell, and a watery consistency. DC H seized the contents of the bottle. Again, testing detected water rather than medication. Another bottle seized labelled oxycodone returned similar results.
24. The police investigation resulted in no further action and was closed around 17 September 2018.

Allegation 8

25. Hair samples were taken from the Registrant and analysed by Dr C. Several drugs were identified in the hair samples, including morphine, oxycodone, cocaine and

amphetamines and were found to be positive for the 7-month period prior to sampling. Dr C concluded that the results confirmed repeated use of amphetamine, morphine and oxycodone, and occasional use of cocaine.

26. Further testing was carried out by Cansford Laboratories upon request of the Council based on body hair obtained from the Registrant. The above substances were not detected but high levels of codeine were detected. Codeine was also detected August – November 2018.

Allegation 9

27. Subsequent correspondence with the pharmacy confirmed that there was no record of who had acted as the responsible pharmacist on various dates in 2018. It was subsequently confirmed by the pharmacy that the Registrant had been the responsible pharmacist and failed to make the relevant entry.

The case on behalf of the Registrant

28. In support of his case a defence bundle (Document 4) of 218 pages was submitted, including evidence relating to the factual particulars and testimonials and character references.
29. Mr Haycroft on behalf of the Registrant further submitted a defence skeleton (Document 6) and defence statement of case (Document 5). His oral submissions at Stage 1 were further supported by written submissions (Document 16) of 24 pages.
30. Mr Haycroft also set out the legal framework and relevant authorities on which he relied. In fact there was no dispute of consequence with the Council in relation to this.
31. The Committee carefully considered all of these submissions.

Consideration of disclosure of further material

32. Mr Wallis representing the Council informed the Committee that there may be material including call logs from the Registrant's mobile phone in the possession of police. It was agreed between the parties that there was no realistic possibility of obtaining the material "within the currency of this hearing". In the circumstances, both parties made no further application for disclosure. The Committee accepted the shared position of the parties.

Decision on Facts

33. 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 those made on behalf of the Registrant.
34. The Committee accepted the advice of the Legal Adviser
35. 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.

Allegation 1:

- (a) PROVED** – The Committee was satisfied that that the Registrant had, on one or more occasions, caused or allowed Oramorph/morphine sulphate to be substituted with water or another liquid including water.
- (b) PROVED** – The Committee was satisfied that the registrant had caused or allowed oxycodone hydrochloride to be substituted with water or another liquid including water.

36. The Committee accepted the evidence of Patient A and MA that Oramorph/morphine sulphate was more likely than not substituted with water on a least one occasion. The Committee noted that there was not sufficient evidence before it suggesting the Registrant had substituted the Oramorph/morphine sulphate himself. However, it took into account DH's statement in relation to the finding and seizure of it by the police, and also took into account that the Registrant had permitted another individual not employed by the Pharmacy to have unsupervised access, including outside Pharmacy opening times, to the Pharmacy during the period to which the allegations refer. This included access to the room in which Oramorph/morphine sulphate and other controlled drugs were stored and to a corridor in which prescription only medications were temporarily stored after being delivered to the Pharmacy and before being dispensed to patients. It was therefore of the view that the Registrant more likely than not has caused or allowed Oramorph/morphine sulphate to be substituted with water.
37. For similar reasons, the Committee was satisfied that the Registrant had caused or allowed oxycodone hydrochloride to be substituted with water or another liquid. The evidence of the bottle seized by the police in the Pharmacy demonstrated that the substitution had occurred, and the Committee was satisfied that the Registrant bore responsibility for causing this or allowing this to happen.

Allegation 2:

PROVED

38. The Committee accepted the evidence of Patient A, MA, Patient Medication Record (PMR), the Police and the Registrant himself noting that these accounts were mutually supportive and consistent. Taken together, the evidence demonstrated that the Registrant had supplied Patient A with bottles labelled as Oramorph/morphine sulphate, which, as established under Particular 1, had been substituted with water.

39. In light of this consistent evidence, the Committee was satisfied that the Registrant caused or allowed the substituted liquid to be supplied to Patient A when she was expecting to receive Oramorph/morphine sulphate.

Allegation 3:

- (a) NOT PROVED**
- (b) NOT PROVED**
- (c) NOT PROVED**

40. The Committee accepted the evidence that one or more bottles supplied to Patient A did not contain Oramorph/morphine sulphate. However, it found no evidence before it establishing that the Registrant was aware of this at the time of supplying. In the absence of evidence demonstrating the Registrant's prior knowledge of any substitution, the Committee could not be satisfied that the Registrant supplied the bottle(s) not containing Oramorph/morphine sulphate knowingly and/or acted dishonestly.

Allegation 4:

- (a) NOT PROVED – It was not proved that the visit was late at night**
- (b) PROVED**
- (c) NOT PROVED**
- (d) NOT PROVED**
- (e) NOT PROVED**
- (f) NOT PROVED**
- (g) NOT PROVED**
- (h) PROVED**

41. The Committee considered the evidence of Patient A that she received a visit from the Registrant to her home at night during which he demanded the return of a bottle that had recently been dispensed to her and that she had alleged did not contain Oramorph/morphine sulphate and acted in a way which caused her distress and pain. It noted some inconsistencies in details including dates within Patient A's evidence.
42. The Committee also considered the Registrant's account that although he had visited Patient A's home at night, but that no Oramorph/morphine sulphate had recently been dispensed to Patient A and that he only dispensed and delivered medication in response to a call that he had received on his mobile phone from Patient A earlier that evening. The Registrant had previously given his mobile number to Patient A and told her to contact him directly should she need to. He told the Committee that he had been dining out with others when he received the call, and that he had left the meal early in order to return to the Pharmacy to dispense and then deliver morphine oral solution to Patient A because she had told him she was in pain and needed it urgently. The Committee further considered the evidence in Patient A's PMR record which indicated that morphine oral solution was dispensed at 21:36. It also noted that the Registrant had attempted, but had not been successful in, recovering phone call records from his device which had been seized by the police to support his account of the evening.
43. The Committee was satisfied that at least one home visit did occur. It was also satisfied that there was a visit during which the Registrant asked Patient A to return the empty bottle referred to in Particular 4(h), and that Patient A was in her own home at the time, as set out in Particular 4(b). The Committee also accepted that Patient A became distressed during the interaction. It considered that the Registrant ought to have appreciated Patient A's vulnerability and his responsibilities as a caring professional.
44. However, the Committee found insufficient evidence to establish the remaining particulars. While it did find from the evidence of the Registrant and the PMR

records of Patient A that a visit to the home had taken place at night, it did not find sufficient evidence that this was the visit during which Patient A became distressed. On the balance of probabilities, it considered that it was more likely than not that this visit took place the following day, in response to contact made by the Care Agency expressing concern that the bottle dispensed the previous evening had not contained oral morphine solution.

45. The Committee considered the contemporaneous care logs for Patient A supplied by the Care Agency, alongside the evidence of Patient A and the Registrant. The Committee was not satisfied that there was sufficient evidence before it to find, on the balance of probabilities, that the Registrant barged past the door, caused Patient A pain, acted with any form of “menace” or instructed her to take medication she had refused. The Committee therefore could not be satisfied that the behaviour alleged in Particulars 4(c)-(g) occurred.

Allegation 5:

(a) – (e) – NOT PROVED

46. The Committee was not satisfied that any of these particulars were proved. The Registrant shared his home with another individual, and there was no evidence before the Committee to show that he was aware of the contents of the backpack and/or the bottle in which the items were found. In the absence of evidence demonstrating knowledge or control, the Committee could not be satisfied that the Registrant possessed these substances.

Allegation 6:

(a) – (k) inc. ALL NOT PROVED

(l) – PROVED by Admission

47. The Committee could not be satisfied that photographs supplied by the police of controlled drug registers were taken at the Registrant's home.

Allegation 7:

PROVED

48. Proved by admissions in respect of 6(l).

Allegation 8:

(a) PROVED by Admission

(b) PROVED

(c) NOT PROVED

(d) NOT PROVED

(e) PROVED

49. The Committee considered the toxicology evidence in relation to Particular 8. It concluded on the balance of probabilities that a false positive was unlikely. The substances identified in the report were some of the same drugs later recovered from the Registrant's home during the police search. While it was not found on the balance of probabilities that the Registrant was knowingly in possession of those drugs on the specific date identified in Particular 5, their discovery by the police nonetheless provides corroborative evidence of the presence of these substances in the home at or around the material time, which supports the reliability of the relevant ChemTox toxicology findings. The Committee was, however, satisfied that only some of the particulars were proved.

50. In respect of Particular 8(a) relating to morphine, the Committee accepted the Registrant's admissions. This particular was therefore found proved by admission.

51. With regard to Particulars 8(b) and 8(e), concerning oxycodone and amphetamine, the Committee determined that the facts were proved on the balance of probabilities. These findings were supported by the ChemTox report, which demonstrated levels significantly above the expected range. The Committee also noted that while oxycodone and amphetamine were not identified in later toxicology reports, the period from January to June 2018 was not covered by the second and third reports.
52. The presence of these substances was consistent with the items recovered during the police search. While MD advised that the results should be afforded limited weight, the Committee considered the totality of the evidence and was satisfied that these two sub particulars were found proved on the balance of probabilities.
53. However, in relation to Particulars 8(c) and 8(d), concerning cocaine and narcocaine [sic], the Committee was not satisfied that the levels detected were sufficiently high to support a finding of their consumption. In light of MD's advice and the comparatively low readings, the Committee determined that these particulars were not proved.

Allegation 9:

PROVED

54. The Committee considered the evidence before them and was satisfied that the Registrant was more likely than not the Responsible Pharmacist on at least one of the days between January and August 2018. It also noted that the Superintendent Pharmacist, which in this case was the Registrant, shares a responsibility for ensuring that responsible pharmacist logs are properly maintained. The Committee therefore found this allegation proved.

Misconduct and Impairment

55. Misconduct - 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.
56. 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."

57. The Committee took into account the submissions made by Mr Wallis on behalf of the Council and Mr Haycroft on behalf of the Registrant. It also considered further written evidence on behalf of the Registrant, including reflections and records of CPD.
58. Mr Wallis submitted on behalf of the Council that there is no dispute that the facts proved amount to misconduct. He referred the Committee to the Council's original statement of case setting out the relevant law:

- *Roylance v GMC (No.2)* [2000] 1 A.C. 311:

"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 by a medical practitioner in the particular circumstances."

- *Aremu v Health and Care Professions Council* [2018] EWHC 978 (Admin)

59. It was accepted on behalf of the Registrant that there is misconduct in this case on the facts as found proven.
60. The Committee accepted the advice of the Legal Adviser.

Decision on Misconduct

61. When considering whether the particulars found proved amounted to misconduct the Committee took into account the Fitness to Practice hearings and Outcomes Guidance 2024 ('the Guidance').
62. The Committee considered whether the Registrant had breached any of the Council's Standards for Pharmacy Professionals (May 2017). The Committee determined that there had been a breach of the 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 VII – to respect maintain the persons confidentiality and privacy
63. 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).
64. The Committee decided in respect of the grounds as follows:
- Allegations 1 and 2 – amounted to misconduct. The Registrant's conduct fell short of what was expected in Standard I and V. The Committee was of the view that he had facilitated the allegations and it was very serious.
 - Allegations 4(b) and (h)- The Committee felt that whilst the Registrant ought to have appreciated the vulnerability of Patient A and whilst his conduct did fall short of what was expected and required, it did not amount to misconduct. The Committee was of the view that his conduct was ill-advised and inappropriate.

- Allegations 6 and 7 – The Committee was of the view that this amounted to misconduct. This was accepted by the Registrant. The Committee noted that there was also a failure to adhere to a Statutory Duty.
 - Allegation 8 – This amounted to misconduct. Although the drugs had been consumed some time ago, they were being taken without there being a valid medical reason for doing so. There was no legal reason or clinically valid prescription for taking them.
 - Allegation 9 – The Registrant had failed in his duty, both as a Responsible Pharmacist, on those days when he acted in that capacity, and in his overarching responsibilities as the Superintendent Pharmacist throughout the period in question. He had also failed to take his responsibilities sufficiently seriously. His failure to keep his records up to date and maintain an appropriate oversight of the pharmacy’s activities was serious and amounted to misconduct.
65. While it was accepted by the Committee that [PRIVATE] at the time had contributed significantly to the serious failings in his professional judgement, including in medicine safety and record keeping, as a registered professional the Registrant should have recognised the problem and stopped practising until it was fully resolved.
66. The Committee therefore did go on to consider whether the Registrant’s fitness to practise is impaired.

Decision on Impairment

67. Having found that the particulars of allegation amounted to misconduct, the Committee went on to consider whether 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;*
- *means that the integrity of the registrant can no longer be relied upon.*

68. The Committee accepted the submissions made on behalf of the Registrant that since the time of the Allegations in 2018, there had been no repetition or reoccurrence. He has since had 8 years of unrestricted practice. It also accepted that the Registrant appears to have developed insight.
69. The Committee also considered the testimonials received from the Registrant's colleagues and his reflection statement.
70. The Committee had sight of submissions made by Mr Wallis on behalf of the Council. He submitted that the conduct was of a sort which created a real danger to a member of the public, both directly to Patient A and more generally arising from the potential risks associated with the mis-supply of medication. The abuse of drugs by a pharmacist brings a profession into disrepute. He stated 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 a manner found proved and would expect the regulator to make finding of impairment in the wider public interest in order to send a message to the public and the profession.'*
71. Mr Haycroft submitted that the Registrant accepts that he is currently impaired on public interest grounds but no longer on public protection grounds.
72. The Committee took into account that the Registrant has been practising unrestricted for many years without any repetition of the matters which had arisen in 2018, and has been able to provide a number of relevant testimonials in support of his personal and professional conduct over this period. It also took into account his reflections on where he fell short and was satisfied from the evidence before it that

the Registrant has developed sufficient insight over the past years. The Committee was of the view that his CPD, reflective accounts and sustained period of safe and effective practice without regulatory concerns provided evidence that he has remediated those findings which relate to public protection, and that the risk of repetition and of consequential harm has therefore reduced significantly.

73. For the above reasons, the Committee has not found any current impairment on public protection grounds.
74. The Committee however was of the view that the misconduct found was serious and had the potential to bring the profession into disrepute. He had not conducted himself in a manner that is expected from a registered pharmacy professional, and had fallen significantly short of several of the Standards for Pharmacy Professionals. It determined that a finding of current impairment is necessary to mark the seriousness of the Registrant's misconduct and thereby maintain public confidence and promote professional standards by making clear to other professionals what is expected and deterring other professionals from failing to meet standards.
75. 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

76. 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.
77. The purpose of any sanction is not to be punitive, though a sanction may in fact have a punitive effect. The purpose of a sanction 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.

78. The Committee had regard to the Council's '*Good decision making: Fitness to practise hearings and outcomes guidance*' to inform its decision.
79. The Committee took into account the submissions made by Mr Wallis and Mr Haycroft. It noted that whilst the parties were in agreement that it would not be appropriate for the Committee to either take no action, or to order the Registrant's removal from the register, Mr Wallis had submitted that the appropriate and proportionate outcome would be a suspension of six months whereas Mr Haycroft had submitted that either a warning or a short period of suspension may be appropriate in this case.
80. The Committee accepted the advice of the Legal Adviser.
81. The Committee first considered what, if any, aggravating and mitigating factors there may be.
82. The Committee identified some aggravating factors, including:
 - a. The duration of the misconduct. This took place over a lengthy or extended period of time. There were two separate instances in which medication was substituted, and in addition there had been a consistent failure to maintain the RP logs over a significant period of 8 months.
 - b. During the relevant period, the running and management by the Registrant of the pharmacy fell far short of the standard expected. The Registrant was both the Superintendent Pharmacist throughout the relevant period, and the Responsible Pharmacist on most occasions during it, each of which was a designation accompanied by its own statutory duties and professional responsibilities. There was therefore a greater responsibility on him to ensure that it was managed properly and professionally.

- c. The impact on Patient A. There was distress caused to Patient A, a patient prescribed pain management medication for a chronic condition, as a result of not receiving the appropriate medicine when she needed it.
- 83. The Committee identified some mitigating features including:
 - a. The Registrant had accepted his failures and expressed remorse for what had happened. He apologised and did not attempt to minimise his actions;
 - b. The Registrant showed insight and accepted full responsibility for what had happened;
 - c. It has been 8 years since the time of the incidents and he practised safely and effectively throughout;
 - d. There were a number of very favourable testimonials which attested to his professional practice in the periods both before and after the time in which the misconduct occurred.
- 84. The Committee also considered and took into account [PRIVATE] which undoubtedly contributed to his stress.
- 85. To take no action. The Committee was of the view that the allegations were too serious to take no action and to do so would not be appropriate.
- 86. Warning. The Committee determined that a Warning would not be sufficient to meet the public interest in the outcome. The Committee concluded that these were wide-ranging failures in which RP logs were inappropriately completed over a period of about 8 months, prescription drugs were substituted, a controlled drug register was removed from the pharmacy premises and controlled drugs were consumed by the Registrant without a valid prescription. The Committee was of the view that a Warning would not meet their concerns or satisfy the public interest by marking the severity of the conduct.
- 87. 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, and would 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.

88. 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.
89. The Committee was of the view that there were no relevant or proportionate conditions which could be imposed to meet the public interest in this case.
90. 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 unbecoming a member of the pharmacy profession. Also, when public confidence in the profession demands no lesser sanction."

91. The Committee considered that a period of Suspension was the most appropriate and proportionate outcome. In considering the length of the suspension, the Committee took into account *Giele v. GMC [2005] EWHC 2084* in which Collins J said there was a public interest in retaining competent clinicians.
92. The Committee considered that Suspension for a period of 4 months was both proportionate and appropriate to satisfy the public interest by marking the seriousness of the misconduct. The Committee was of the view that a longer period of suspension is disproportionate as he has been practising safely for about 8 years.

93. Removal. Given the above conclusions, and taking account of the seriousness of the matter, the Committee concluded that an outcome of removal would be disproportionate.
94. The Committee therefore directs that the Registrar suspends the Registrant for a period of 4 months.
95. Given its prior finding that the Registrant had remediated his misconduct and that impairment was found on public interest grounds only, the Committee determined that the decision to suspend the Registrant did not require review before its expiry.

Decision on Interim Measure

96. The Committee accepted the submissions from both parties that Interim Measures were neither necessary nor appropriate in this case given the finding of impairment on public interest grounds only and the absence of any existing Interim Order. The Committee therefore imposed no Interim Measure.
97. This concludes the determination.