

General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Remote videolink hearing

13-24 April 2026

12-15 October 2026

Registrant name:	William Terry Obeng
Registration number:	2087223
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Neville Sorab (Chair) Sukvinder Bhamra (Registrant member) Stephanie Hayle (Lay member)
Committee Secretary:	Chelsea Smith/Evie Davies/Ivana Raimundova
Registrant:	Present and represented by Mr Michael Smalley
General Pharmaceutical Council:	Represented by Mr Leonard Wigg, Case Presenter
Facts proved:	1.1, 1.2, 1.3, 2.2, 5.4, 5.6, 6.1, 6.2, 6.4, 7.5
Facts proved by admission:	2.1, 3, 4, 5.1, 5.2, 5.3, 5.5, 5.7, 6.3, 7.1, 7.2, 7.3, 7.4, 7.6, 7.7, 7.8
Facts not proved:	None
Fitness to practise:	Impaired
Outcome:	Suspension – 6 months

Interim measures:

Interim 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 **13 November 2026** or, if an appeal is lodged, once that appeal has been concluded. However, the interim suspension set out in the decision takes effect immediately and will lapse when the decision takes effect or once any appeal is concluded.

Particulars of Allegation (as amended)

You a registered pharmacist,

1. Whilst working for UK Meds Direct Ltd between approximately 5 November 2019 and 23 February 2022, you prescribed and, or approved:

1.1 around, or up to 20 prescriptions for high risk controlled medicines;

DENIED

*1.2 around, or up to 5,303 high risk non-controlled medicines; **DENIED***

*1.3 around, or up to 47,024 not high-risk, and/or not habit-forming medicines, but may require ongoing monitoring and management. **DENIED***

2. Whilst working for Prescription Doctor, connected to Halliwell Midnight Pharmacy between approximately 20 January 2022 and 2 May 2022, you prescribed and or approved:

*2.1 around, or up to 2,920 prescriptions for high risk non-controlled medicines; **ADMITTED***

*2.2 around, or up to 10,217 not high-risk, and/or not habit-forming medicines, but may require ongoing monitoring and management. **DENIED***

*3. Whilst working for PillDoctor connected to Aktive Pharmacy between approximately 3 August 2021 and 06 June 2022, you prescribed and, or approved around, or up to 2,960 prescriptions. **ADMITTED***

*4. Whilst working for Pharmacorp, connected with Medicines Direct as a prescribing pharmacist between approximately 6 April 2022 and 06 June 2022, you prescribed and, or approved prescriptions in the manner set out in 5 and 6 below. **ADMITTED***

5. In relation to 1, 2, 3 and/or 4 above, you failed to prescribe medicines in accordance with and/ or pay due regard to the relevant guidance on prescribing from the General Medical Council ("GMC"), the Royal Pharmaceutical Society ("RPS") and/ or the General Pharmaceutical Council ("GPhC") in that you prescribed in circumstances where you:

5.1 failed to obtain adequate information in relation to the patients' health in advance of prescribing; **ADMITTED**

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

5.3 failed to access and/ or attempt to access patients' General Practitioner ("GP") medical records and/ or specialist clinical records in order to have a full picture of their physical and/ or mental health, currently prescribed medication and/ or addiction history; **ADMITTED**

5.4 failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication; **DENIED**

5.5 failed to adequately consider the possibility of medication dependence and misuse; **ADMITTED**

5.6 failed to refer patients back to their GP for appropriate assessment and/ or review and/ or monitoring; and/ or **DENIED**

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

6. In relation to 1, 2, 3 and/or 4 above, you prescribed in circumstances where the prescribing model or service was incapable of supporting safe prescribing decisions in that:

6.1 no face-to-face or other virtual consultation took place other than the use of a questionnaire; **DENIED**

6.2 patients were allowed to pre-select the medicine, strength, and quantity they desired; **DENIED**

6.3 patients provided information primarily through a questionnaire; **ADMITTED**

6.4 the questionnaire at 6.3 above could easily be manipulated by patients as it highlighted to them answers which could prevent the supply of the medication they desired and permit the patient to change their answer. **DENIED**

7. In relation to 1 above, on or around 14 June 2021, you prescribed Propranolol to Patient A, a patient with a history of poor mental health and/ or self-harm in circumstances where you:

7.1 knew or should have known that the patient had made a previous and or/ repeated orders for the same medicines from UK Meds Direct Ltd;

ADMITTED

7.2 failed to obtain adequate information in relation to the patient's health in advance of prescribing; **ADMITTED**

7.3 relied principally on the information received in an online questionnaire; **ADMITTED**

7.4 failed to access and/ or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/ or mental health, currently prescribed medication and/ or addiction history; **ADMITTED**

7.5 failed to request a face-to-face consultation with the patient in order to adequately examine the clinical need for medication; **DENIED**

7.6 failed to adequately consider the possibility of medication dependence and misuse; **ADMITTED**

7.7 failed to refer the patient back to their GP for appropriate assessment and/ or review and/ or monitoring; **ADMITTED**

7.8 failed to put adequate safety-netting in place. **ADMITTED**

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

Documentation

Document 1- Council hearing bundle

Document 2- Council skeleton

Document 3- Registrant bundle

Document 4- Registrant's reflective log

Document 5- Exhibit SO/1

Document 6- Exhibit SO/2

Document 7- Registrant's Prescribing Data – Halliwell Pharmacy

Document 8- Exhibit FV/03

Document 9- Exhibit FV/05

Document 10- Council file note dated 7 August 2024

Document 11- Additional Statement of MA

Document 12- Exhibit MA/08

Document 13- Reference of Dr A

Document 14- Interim Order Review Decision of Mr Obeng dated 8 and 9 January 2026

Document 15- Interim Order Review Decision of Mr Obeng dated 7 July 2026

Determination

Introduction

1. This is the written determination of the Fitness to Practise Committee at the General Pharmaceutical Council ("the Council").
2. The hearing is governed by *The Pharmacy Order 2010* ("the Order") and *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010* ("the Rules").
3. The statutory overarching objectives for these regulatory proceedings are:
 - a. To protect, promote and maintain the health, safety and well-being of the public;

- b. To promote and maintain public confidence in the professions regulated by the Council; and
 - c. To promote and maintain proper professional standards and conduct for members of those professions.
- 4. The Committee also has regard to the guidance contained in the Council's *Good decision making: Fitness to practise hearings and outcomes guidance* as revised March 2024.
- 5. A Principal Hearing has up to three stages:
 - Stage 1. Findings of Fact – the Committee determines any disputed facts.
 - Stage 2. Findings of ground(s) of impairment and impairment – the Committee determines whether, on the facts as proved, a statutory ground for impairment is established and, if so, whether the Registrant's fitness to practise is currently impaired.
 - Stage 3. Outcome – the Committee considers what, if any, outcome 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 18 February 2026 from the Council headed "*Notice of Hearing*" sent by email to the Registrant. The Notice of Hearing was sent more than 28-days prior to the commencement of the hearing, stated the date, time and venue of the hearing, and also contained the finalised particulars of the allegation. The Committee was satisfied that there had been good service of the Notice in accordance with Rules 3 and 16.

First application to amend the particulars of allegation

- 7. Under Rule 41, the Council made an application to amend allegations 3, 4, 5, 6 and 6.4 as follows (additions in underline and removals in strikethrough), due to the

amendments being technical, which does not materially amend any of the allegations and would, therefore, not prejudice the fairness of the proceedings:

3. Whilst working for PillDoctor connected to Aktive Pharmacy between approximately 3 August 2021 and ~~10-06~~ June 2022, you prescribed and, or approved around, or up to 2,960 prescriptions.

4. Whilst working for Pharmacorp, connected with Medicines Direct as a prescribing pharmacist between approximately 6 April 2022 and ~~26-July~~06 June 2022, you prescribed and, or approved prescriptions in the manner set out in 5 and 6 below.

5. In relation to 1, 2, 3 and or 4 above...

6. In relation to 1, 2, 3 and or 4 above...

6.4 the questionnaire at ~~6.34.1~~ above could easily be manipulated by patients as it highlighted to them answers which could prevent the supply of the medication they desired and permit the patient to change their answer.

8. On behalf of the Registrant, Mr Smalley did not oppose the amendments.
9. The Committee considered the amendment to clarify the allegations which do not materially amend any of the allegations and would, therefore, not prejudice the fairness of the proceedings. The Committee allowed the amendments.

Application to disregard evidence

10. Prior to the commencement of the substantive Principal Hearing, the Council intended to add a further allegation, allegation 8. However, at the start of the Principal Hearing, the Council decided that it no longer wanted to add allegation 8. However, pages 2629 to 3087 of the Council's bundle were evidence concerning allegation 8. Consequently, on behalf the Registrant, Mr Smalley requested the Committee to disregard pages 2629 to 3087 of the Council's bundle.

11. The Committee confirmed that it was a professional Committee which was capable of removing from its mind material which is no longer relevant. The Committee confirmed that it would disregard pages 2629 to 3087 of the Council's bundle. The Committee asked the parties whether as a result of the Committee, having seen pages 2629 to 3087 of the Council's bundle, whether it should be recused on the basis of perceived bias. Both parties were content for the Committee to continue with the Principal Hearing.

Application for the hearing to be heard in private in part

12. On behalf the Registrant, Mr Smalley made an application to the Committee to hear any evidence provided by the Registrant concerning his health or the health of his family to be heard in private, pursuant to Rule 39(3)(b). On behalf of the Council, Mr Wigg did not oppose the application.
13. The Committee agreed to the application to hear any evidence provided by the Registrant concerning his health or the health of his family to be heard in private, pursuant to Rule 39(3)(b). The Committee considered that maintaining the Registrant's and the Registrant's family privacy, in relation to their health, outweighed the public interest in holding that part of the hearing in public.

Application for disclosure

14. On behalf the Registrant, Mr Smalley made an application for the Committee to order the Council to provide the raw data which formed the analysis contained in exhibit SO/1. Allegation 1 reads "*between approximately 5 November 2019 and 23 February 2022*", however, the Registrant claimed that he did not work on 23 February 2022 and the last date of entry was a prescription on 23 September 2021. The Registrant was concerned that if there is an error with this date, there may be errors with other dates in the allegations.
15. Mr Wigg, on behalf of the Council, opposed the application on the basis that exhibits SO/1 and SO/2 were sufficient to contain the information relevant for the allegations.

The raw data includes a significant amount of personal information, and it would be disproportionate to disclose it.

16. The Committee asked the Council whether:
 - a. It was in possession of the raw data; and
 - b. If so, whether it would be possible to redact personal information from the raw data.

Mr Wigg confirmed that the Council was in possession of the raw data and was able to redact personal information from the raw data. Prior to any decision being made by the Committee, the Council disclosed the redacted raw data to the Registrant. The Council will formally exhibit the raw data with an exhibiting statement.

Admissions

17. Through Mr Smalley, when read out, the Registrant admitted to the following allegations: 2.1, 3, 4, 5.1, 5.2, 5.3, 5.5, 5.7, 6.3, 7.1, 7.2, 7.3, 7.4, 7.6, 7.7, 7.8. The Committee accepted that the Registrant has admitted to these allegations. By the application of Rule 31(6), the admitted factual allegations were found proved. The Committee proceeded to determine the rest of the allegations, those being allegations 1.1, 1.2, 1.3, 2.2, 5.4, 5.6, 6.1, 6.2, 6.4, 7.5.
18. In relation to allegations 1.1, 1.2, 1.3 and 2.2, the Registrant narrowed the issues in that the only disputed part of the allegation is that of the number of prescriptions/medicines referred to in each allegation.

First Application to admit further evidence

19. On behalf of the Registrant, Mr Smalley made an application to admit a file note from the Council dated 7 August 2024 (the “file note”), which was in the unused material. The file note is a discussion concerning data provided by UK Meds to the Council. This was relevant information as it had been referred to in FV’s statement and it was

fair to admit as it was evidence already in the possession of the Council, so it would not cause the Council prejudice.

20. On behalf of the Council, Mr Wigg opposed the application on the basis that:
 - a. FV was not a party to the conversation which resulted in the file note;
 - b. FV would only be able to comment on a limited amount of the file note;
 - c. The file note contained hearsay which could result in FV using it to speculate; and
 - d. The file note does not go to the issue in allegations 1 and 2; that of the quantity of medication/prescriptions.
21. Given the file note was in the possession of both parties and formed part of previous bundles, the Committee did not consider that its admission fell under Rule 18(5). Consequently, the Committee considered the file note's admission under Rule 24(2), namely whether the admission of the file note was relevant and fair. The Committee considered it relevant and fair to admit the file note on the basis that:
 - a. The file note was relevant as it resulted in a new statement being drafted by FV; and
 - b. It was fair to admit as all parties, and FV, were in possession of the files note prior to this hearing. Consequently, there would be no prejudice in admitting the file note.

Second Application to admit further evidence

22. On behalf of the Registrant, Mr Smalley made an application to admit a dissertation project from the Registrant ("Dissertation Project"). The Dissertation Project was disclosed to the Council and the Committee as it formed part of pages 2629 to 3087 of the Council's bundle which the Committee was asked to disregard. Therefore, the application was not made under Rule 18(5), but the Committee was asked to determine whether the Dissertation Project was relevant and fair to admit.

23. On behalf of the Registrant, Mr Smalley submitted that the Dissertation Project was relevant as the Registrant sets out within it, the pros and cons of remote prescribing which would be put to witness Dr C. Furthermore, it was fair for the Dissertation Project to be admitted as all parties and the Committee had sight of it and it does not relate to any of the removed charges.
24. On behalf of the Council, Mr Wigg set out that Dr C did not have sight of the Dissertation Project and he is unaware of the allegations to which the Dissertation Project goes to.
25. The Committee admitted the Dissertation Project on the basis that it would assist Dr C and the Committee if the Registrant's considered pros and cons are known and it was fair on the basis that all parties, and the Committee, already had sight of the Dissertation Project.

Background

26. The Registrant is a prescribing pharmacist registered with the Council. He was first registered on 1 August 2014 and he was licenced as a prescribing pharmacist in September 2018. Since qualifying as a prescribing pharmacist the Registrant worked in a number of prescribing positions in pharmacies specialising in providing prescriptions online. These included:
 - a. UK Meds Direct Ltd: between approximately 5 November 2019 and 23 February 2022;
 - b. Halliwell Midnight Pharmacy: between approximately 20 January 2022 and 2 May 2022;
 - c. PillDoctor (connected to Aktive Pharmacy) between approximately 3 August 2021 and 10 June 2022; and
 - d. Pharmacorp, (connected with Medicines Direct) between approximately 6 April 2022 and 26 July 2022.

UK Meds Direct Limited

27. UK Meds Direct Limited (“UK Meds”) was an online only pharmacy. It was first registered with the Council on 15 August 2017 under registration number 9010688 at Unit 1 Hawksworth Road, West Bridgford, Nottingham NG2 5FT (UK Meds’ first pharmacy premises). UK Meds’ first pharmacy premises was voluntarily removed from the Council’s register on 11 March 2019. UK Meds’ second pharmacy premises was first registered with the Council on 1 March 2019 under registration number 9011117 at Unit 3, Castlebridge Office Village, Castle Marina Road, Nottingham, NG7 1TN. UK Meds’ second pharmacy premises was voluntarily removed from the Council’s register of pharmacies on 7 September 2021.
28. Following an inspection on 3 September 2019 UK Meds did not meet required standards, including:
- a. It supplied higher-risk medicines to people, and it was not managing all the risks associated with this properly.
 - b. UK Meds did not regularly carry out audits to review the safety and quality of its services.
 - c. UK Meds did not safeguard vulnerable people because it did not have sufficient safeguards to make sure that supplies of medicines liable to abuse, overuse or misuse were appropriate.
 - d. UK Meds’ website allowed people to select a medicine before a consultation.
 - e. UK Meds did not carry out enough checks to make sure that its medicines were appropriate for people. UK Meds did not ensure that its prescribers are proactively sharing all relevant information about the prescription with other health professionals involved in the patient’s care. For medicines liable to abuse or misuse, or when there was a risk of addiction, and ongoing monitoring is important, UK Meds did not have all the additional safeguards it needs. UK Meds could not give assurances that its prescribers have always contacted the patient’s GP in advance of issuing a prescription.
29. On 27 September 2019 UK Meds was served with an improvement notice requiring it to take action in the following ways by 27 October 2019:

- a. *"You must complete a risk assessment for each part of the service and the medicines supplied, and ensure that regular review audits of risks identified, and reactive review audits of incidents are carried out.*
 - b. *UK Meds website must not allow people to choose the medicines they want before they have had an appropriate consultation with a prescriber.*
 - c. *The consultation questions must not indicate which answers raise questions about whether a medicine is clinically appropriate or allow answers to be subsequently altered without the alteration being visible to the prescriber.*
 - d. *You must ensure that the prescribers you work with work in accordance with the relevant Council guidance to:*
 - i. *proactively share all relevant information about the prescriptions they issue with other health professionals involved in the care of the patient (for example their GP).*
 - ii. *that the prescriber contacts the GP in advance of issuing a prescription to confirm that the prescription is appropriate for the patient and that appropriate monitoring is in place.*
 - iii. *that the prescriber makes a clear record setting out their justification for prescribing, in circumstances where the patient does not have a GP or does not consent to share information."*
30. On 1 November 2019 UK Meds was visited by the Council's enforcement team to check compliance with the improvement notice. Findings following this visit shows that UK Meds' response included that where a patient did not provide consent [to access other care records], there was no additional guidance provided for its prescribers and it was a matter for *"individual prescribers to use their professional judgment"* and that it was *"assumed that the prescriber was clinically competent and able to make an appropriate decision"*.
31. On 8 November 2019, 3 days after the Registrant began working at UK Meds, conditions were imposed on it preventing it selling or supplying any controlled drugs

from Schedule 1 to 5 (as detailed in the Misuse of Drugs Regulations 2001) and Modafinil.

32. On 9 March 2021, further conditions were imposed on UK Meds preventing it from selling or supplying Amitriptyline.
33. On 30 July 2021, further conditions were imposed following findings that *“UK Meds Direct Ltd is proactively facilitating access by people to a service operated by EU Meds Ltd via eumeds.com, including through links on UK Meds Direct Ltd’s own website, through direct text messaging to members of the public, and through information posted on social media.”*
34. UK Meds was voluntarily removed from the register of pharmacies on 07 September 2021.
35. As part of the Council’s investigation, once data requested was obtained from the directors of UK Meds, NR, (a Senior Clinical Advisor and Specialist Inspector at the Council) categorised the prescription only medicines supplied into higher risk medicines (controlled and not controlled) and also set out a list of medications that should be considered that are not habit forming but may require ongoing monitoring and management. This categorisation was made in accordance with the Council’s Guidance for Providing Services at a Distance (March 2022).
36. Using NR’s categorisation, FV (case officer at the Council) applied this to the Registrant’s prescribing data received from UK Med Direct Ltd. This allegedly yielded results as follows:
 - a. Total number of prescriptions issued: 52,347;
 - b. Total number of prescriptions classified as high-risk controlled: 20 (approx. 0.03%);
 - c. Total number of prescriptions classified as high-risk not controlled: 5,303 (approx.10.1%); and
 - d. Total number of prescriptions classified as not high-risk: 47,024 (approx. 89.8%).

37. The number of times a patient's GP was contacted was allegedly 3,712 times (approx. 7% of all prescriptions issued).
38. In terms of high risk not controlled drugs, this includes propranolol, which was allegedly prescribed 2,660 times by the Registrant. Consent was given by the patients to contact their GP for 928 of those prescriptions (less than half). Of those, the Registrant made contact with their GP in 227 cases.
39. For all prescriptions issued for high-risk not controlled medications, if a patient did not give consent for their GP to be contacted, or if consent was not asked for, the Registrant allegedly did not contact the GP. For all prescriptions issued for high-risk not controlled medications where a patient gave consent for their GP to be contacted (1,721 times), the Registrant allegedly only contacted the GP 418 times. This equates to approximately 24.2%.

PillDoctor (connected to Aktive Pharmacy)

40. PillDoctor (connected to Aktive Pharmacy) ("Aktive Pharmacy") was a distance selling pharmacy (www.aktivepharmacy.co.uk). Aktive Pharmacy's premises were on an industrial estate.
41. The Registrant was a prescriber for Aktive Pharmacy between 3 August 2021 and 10 June 2022.
42. On 13 June 2022, three days after the Registrant stopped prescribing for Aktive Pharmacy, it was inspected by the Council. Failings were identified. These included:
 - a. It often supplied high-risk medicines to people without informing their GP. And it was not able to demonstrate the justification for prescribing for people who do not give consent to share information with their GP.
 - b. Aktive Pharmacy did not always conduct sufficient checks to be satisfied the medicines it supplied are suitable. And it did not always follow up with the patients to check how their treatment was working.
 - c. Aktive Pharmacy could not provide assurance that the online prescribing service was making appropriate records about its clinical decisions.

- d. Aktive Pharmacy's safeguarding policy was a generic one for community pharmacies and did not take into account the pharmacy's model or range of medicines supplied.
 - e. Aktive Pharmacy's website contained inaccurate information. And it allowed people to select a prescription-only medicine ("POM") before starting a consultation.
 - f. Aktive Pharmacy did not always make sure enough information was obtained from people to make sure the medicines it supplied were being used safely.
43. Since 3 October 2019, Aktive Pharmacy had conditions on its registration. The conditions imposed were:
- a. Aktive Pharmacy must not sell or supply any controlled drugs from Schedule 1 to 5 (as detailed in the Misuse of Drugs Regulations 2001, as amended), with the exception of supplying these medicines against a legally valid NHS prescription.
 - b. Aktive Pharmacy must not sell or supply any medicines against prescriptions issued by online prescribing services that are not registered with a UK regulator.
44. FV analysed the Registrant's prescribing data received from Aktive Pharmacy, with the following results:
- a. the Registrant issued a total of 2,960 prescriptions via Aktive Pharmacy between 3 August 2021 and 10 June 2022; and
 - b. allegedly only in 8% of the prescriptions issued by the Registrant had the patients provided GP consent.
45. Further investigations allege that:
- a. Aktive Pharmacy's website allowed people to choose a medicine prior to starting a consultation.
 - b. diabetic medicines which were being used off-licence as weight loss medicines.
 - c. there was no actual evidence of any correspondence with GPs when patient had consented.

- d. where the person requesting treatment did not give consent for the pharmacy to share information with their GP, it was seen that the online prescriber did not make any records to explain their justification for prescribing.
- e. where the person requesting treatment did not give consent for the pharmacy to share information with their GP, it was seen that the online prescriber did not make any records to explain their justification for prescribing.
- f. there was no evidence of the pharmacy referring to people's Summary Care Records or obtaining a confirmed clinical summary or medical history from the GP, surgery, or any evidence of looking at a confirmed list of repeat medication the person may be taking.

Halliwell Midnight Pharmacy

- 46. Halliwell Midnight Pharmacy ("Halliwell") dispensed NHS prescriptions and sold a range of over-the-counter medicines. It also had a private prescribing service which people access from its website www.prescriptiondoctor.com.
- 47. The Registrant was the sole prescriber for Halliwell's online prescription service between 20 January 2022 and 2 May 2022. The Registrant would work 7 days a week but his working pattern varied on a weekly basis across different shifts, including days, evenings, and weekends, managing his own time to ensure flexibility and coverage.
- 48. On 12 April 2022, Halliwell was inspected by the Council. Failings were identified. These included:
 - a. Halliwell's risk assessments did not identify all of the risks associated with the prescribing service.
 - b. Halliwell's website used wording that gave people the impression that they could choose a POM before having an appropriate consultation with a prescriber.
 - c. Halliwell was not able to demonstrate that sufficient safeguards were in place to make sure the medicines it supplied through the prescribing service were clinically appropriate. It did not effectively verify the information provided by the

person completing the online questionnaire, or share all relevant information with the patient's regular doctor or ensure that effective monitoring is in place.

49. FV analysed the Registrant's prescribing data received from Halliwell, with the following results:
- a. Total number of prescriptions classified as high-risk not controlled: 2,920 (approx. 22.2%).
 - b. Alleged total number of prescriptions classified as not high risk: 10,217 (approx. 77.7%).
50. The Registrant allegedly prescribed propranolol 784 times and refused it 230 times. The inspection report of 12 April 2022 found:

"The prescribing guidance and risk assessment for situational anxiety effectively allowed the prescriber to diagnose anxiety and initiate a person on either 10mg or 40 mg propranolol. Anxiety is usually a complex mental health condition, often with several overlapping conditions, which needs psychological and physical assessment by a practitioner before a diagnosis can be made. The consultation questionnaire was the same for initiating treatment (diagnosis) and repeat prescribing and it did not consider the additional assessments of patients required to safely initiate the medication."

Pharmacorp, (connected with Medicines Direct)

51. The Registrant was sole prescriber for Pharmacorp. He prescribed between 6 April 2022 and 26 July 2022.
52. On 6 April 2022 Pharmacorp was inspected by the Council. Failings were identified. These included:
- a. Pharmacorp did not identify and mitigate all the key risks through its risk assessment of its private online prescribing service. This included prescribing for higher risk medicines such as cyclizine and propranolol. Pharmacorp's prescribers

and pharmacists did not follow written procedures, creating a risk that people may receive medicines not suitable for their needs.

- b. Pharmacorp did not keep adequate clinical records and did not keep records of correspondence with prescribers. Pharmacorp's prescribers and pharmacists did not make adequate records of the professional decisions they made.
- c. Pharmacorp's website allowed people to select a POM and quantity before starting a consultation. This did not meet Council guidance. Some details on the website were missing, incorrect or misleading. Pharmacorp had not fully completed the actions from this exception standard from the previous inspection.
- d. Pharmacorp did not always have the necessary safeguards and checks in place to ensure people received appropriate care. This included making professional decisions on repeat supplies to individual people and informing people's regular prescribers about the supplies it made.
- e. The overview of Pharmacorp's Standard Operating Procedure ("SOP") detailed the requirements to contact the person's GP depending on the level of risk identified in the risk classification document. There was no indication this document was followed by Pharmacorp's prescribers or the Responsible Pharmacist.
- f. The audit generally showed that in instances where Pharmacorp's prescribers did not have consent to share information with the GP, supplies were still being made without the rationale for the prescribing decision being documented. This was of particular risk when propranolol and medicines for asthma were prescribed. On some occasions, this applied to multiple orders, which may result in people not being appropriately followed up and monitored. The audit included prescribing for propranolol and cyclizine.
- g. The audit showed several examples of repeat prescribing and dispensing of cyclizine where the person had not consented for their GP to be informed. There was no record these supplies had been queried by Pharmacorp's prescribers or pharmacists.

- h. Pharmacorp had an up-to-date prescriber SOP. The SOP detailed it was Pharmacorp's prescribers' responsibility to be competent to prescribe the range of medicines listed on Pharmacorp's website.
 - i. Pharmacorp's prescribers only made clinical records by exception. From the information seen, Pharmacorp's prescribers had not documented their professional decision as to why they refused supplies. And they had not documented why they authorised repeat supplies when people had not consented to share information with their NHS GP.
 - j. In some of the patient medication records, including for people who had been initiated on treatment for propranolol, Pharmacorp's prescribers had prescribed an increase in dose of propranolol. There were no clinical records indicating the confirmation of diagnosis or reason for an increase in dosage.
 - k. There were several examples where propranolol had been supplied without any initial prescriptions from the person's NHS GP or a consultant. Anxiety is a complex mental health condition which needs psychological and physical assessment by a practitioner competent in this area.
 - l. In the records demonstrated, there were examples of people consenting for their GP to be informed of the supply. There were no records on the system to demonstrate if this had happened or the content of the correspondence.
 - m. Some records showed repeat supplies of medicines such as salbutamol, propranolol and cyclizine over months and sometimes years. But as the patient had declined consent to share, their GPs may be unaware of the treatments prescribed and the supplies made. This could impact their decisions about their patient's care.
53. Pharmacorp was subsequently issued an improvement action plan by the Council to be implemented by 25 July 2022.

Death of Patient A

54. On 15 June 2021, whilst working for UK Meds, the Registrant prescribed propranolol to Patient A following an online request for a prescription.

55. Patient A concealed the fact that at that time she was an inpatient at a psychiatric ward. She ordered the propranolol to her home address. The Registrant accepted the information provided by Patient A at face value and she was prescribed a three-month supply.
56. On 19 June 2021 Patient A died from an overdose of the propranolol.
57. During the hearing at the Coroner's Court on 17 January 2023, the Registrant gave sworn evidence. He accepted that his work for UK Med was remote work and that he would work from 7 am to 9 am and then 6pm to 10pm Monday to Friday as well as Sunday evening. When he first started his role at UK Meds he was still doing a few sessions a week in an NHS clinic during its extended hours.
58. The Registrant confirmed that at the time he prescribed, Patient A propranolol on 15 June 2021 he was not aware that she had overdosed on propranolol on 05 June (i.e. 10 days before).
59. He explained the process of considering a prescription request as follows:

"I would then run through the clinical checks, where I'm checking the previous order, previous quantity, any changes in answers. And then make a justification. So the system, I believe, was built where you couldn't approve or reject an order without giving a reason that gets sent back to the patient. So for example, if I'm approving, I have to justify my reasons, which usually, we have a pre-set answer that we use. So each prescriber would have their own kind of format that you'd use to say like, 'This is why I believe it's suitable.' And then you'd add in any extra information.

And then if it's approved, you then give additional information around the condition. So in this case, propranolol, you'd advise on safety-netting. Calling NHS Samaritans charity. Contacting your GP if there's no improvement. And then you'd usually give a list of NHS choices, and referral information. And then if you were rejecting an order, the same principle would apply. You'd have to give a reason why you rejected it.

[...]

I believe when the patient selects the condition, and then the medication, before if – when you press the ‘start consultation’ button, I think there was a message or something that would notify the patient that, similar to [inaudible] something like, ‘The final decision would rest with the prescriber. You’re not guaranteed medication.’ But they were still able to select their preferred product, strength, and quantity. But there was a disclaimer when they hit that consultation button, saying that essentially, ‘this is not guaranteed you will get this medication’.”

60. The Registrant went on to describe Patient A’s request in that she stated in the questionnaire that she did not suffer any allergies; she confirmed her height and weight; that she had capacity to make decisions about her own healthcare; and that she had no further information. She specifically requested propranolol and in the amount of 84 propranolol, 40mg. She stated the reason why she wanted propranolol was that she felt worried due to exam stress, university lifestyle, and the current global climate.
61. The Registrant further describes how at the time he made the prescription he was aware that Patient A had been prescribed 28 propranolol, at a 10mg dose on 1 May 2020. When asked about why he decided to increase her dose, he stated: *“when you have physical symptoms, the 40mg is usually more effective,”* and that he *“felt reassured that she’s given an indication that there’s been some improvement in her symptoms previously, from last year.”* He also stated *“I specifically remember that time of year, because I believe it was when the tier-system was in place in the country. And a lot of people were returning, I think, to face-to-face exams, rather than remote. And there was nothing unusual the about the description that she free typed, that she described the cause of her anxiety.”*
62. In one exchange the Coroner asks the Registrant *“[h]ave you ever rejected a request for a prescription?”* To which he replied: *“Yes. Very, very frequently.”* Followed by a further question from the Coroner *“[h]ave you ever had to reject a request for propranolol?”* To which the Registrant responded *“[m]any times, yeah. That was also frequent.”* The Registrant went on to explain:

“So that would be based on the free-typed answers. So if we’ve gone from when we asked the patients, ‘Please describe the cause of your anxiety.’ Given the information there, majority of times, if people present with symptoms outside of what you’d expect of situational anxiety, then there’s an overlap between the conditions. And having worked in GP practice, and kind of in all the training around that, I know that you usually need a different set of assessment, different set of questionnaire, different face to-face consultation and referral. So those are the cases where they would be rejected with information given to the patient. Sometimes you might call them – just depended on the information they’d free-type. And also if, for example, a patient didn’t free-type any information. But they might have answered, ‘I have a mental health condition.’ Or ‘I’m taking certain medication that’s contraindicated.’ That would also warrant a rejection.”

63. The Registrant confirmed that he knew Patient A had declined consent to share information with her GP. When asked if that caused him any concern the Registrant replied:

“Not particularly. I think within – just generally, my experience working in general practice, and within the online pharmacy – I mean, it’s very, very common for patients to decline consent. Around the time of working – although I’ve always worked within GP practice, I’ve seen both ends as to why patients sometimes say no, and sometimes say yes. I’ve found that, for example, if I – on one occasion, I think, when I rejected an order via online, and I’d called them up just to get some information, they’ve told me they rejected it because similar things that have been touched on before. They don’t want to kind of worsen the relationship with their current GP. Access is difficult. And some patients – I’ve had it fairly often where patients who are applying to work, or possibly are on Universal Credit, things like that – they’re worried about the – kind of, their medical records. Because on their GP system, certain things they do – I’ve found that a lot of that information is shared with work or employers. So that was my experience, generally. So it was very, very common for patients to decline consent for a wide range of

reasons. And from my understanding, it was always the patient's right to decline that.

We'd have safeguard measures in place. So for example if there was ever any indication or reason for us to need to call the GP, or even call the patient, or safeguard, we'd have steps in place, via training from the company to do that. I'd never had to do that, but I know where to refer to, to get that information."

64. The jury in the inquest concluded that Patient A's death was caused by suicide with intent and:

"The death was contributed to by the ineffectiveness of all searches but in particular to the search on 18 June 2021, inadequate post-leave assessment and the omission of Safety Plans which reflect the risks posed to on 18 June 2021.

In respect of the online pharmacies, there was a:

- a) Lack of integrated system or records which could be accessed by multiple pharmacies*
- b) Lack of access to the GP Summary Care Records, other pharmacy supplies; and*
- c) Lack of consent to the sharing of information.*

65. The Coroner's concerns included:

"The MATTERS OF CONCERN in relation to on-line prescribing are as follows:

(1) Whilst each individual pharmacy had in-house safety checks to safeguard against overprescribing by their own pharmacy, there is no integrated system in place which would alert a prescriber to prescriptions that have been dispensed by other on-line pharmacies. As a result, it is currently possible for a patient to obtain excessive quantities of medication by simply placing multiple orders with different on-line pharmacists.

(2) There is no requirement for the on-line pharmacies to share information with the patient's GP. This means that, in the absence of the patient's consent to share information, the online prescriber is reliant on the accuracy and truthfulness of the history provided by the patient.

(3) Lack of information sharing also creates a risk that a GP or Pharmacist Prescriber may unwittingly prescribe a medication that is contraindicated with a medication that has been dispensed through an on-line pharmacy."

Evidence

66. The Committee received oral evidence from FV who stated the following:
- a. She took over the investigation into the Registrant on 11 April 2024.
 - b. The Registrant's prescribing data was provided to the Council by UK Meds on 11 October 2022 and 1 February 2023, which was subsequently amalgamated by Senior Data Analyst and Insight Manager at the Council, SO. SO created two spreadsheets from this data (the "Spreadsheets"):
 - i. Combined List – With Customer Name Removed (SO/1); and
 - ii. Combined List – High Risk – With Customer Name Removed (SO/2).
 - c. The information contained within the "Combined List – With Customer Name Removed" is not limited to POMs and includes items on the General Sales List or over the counter medicines. NR, Senior Clinical Advisor and Specialist Inspector at the Council has categorised the POMs into what she regards to be higher risk medicines: controlled and not controlled.
 - d. She looked at the prescribing data relating to the prescriptions approved by the Registrant by using the "Combined List – With Customer Name Removed" and filtering the "prescriber_name" column to "William Obeng". She then filtered the data in the "review_date" column to "sort oldest to newest". This showed her the Registrant approved prescriptions between 5 November 2019 and 23 February 2022. However, the Registrant had only issued one prescription on 23 February

2022 and prior to this, had last prescribed on 23 September 2021. FV did not know why one prescription was allocated as dispensed by the Registrant on 23 February 2022.

- e. In the disclosure provided by UK Meds on 31 May 2023, it confirmed that the Registrant was employed as a prescriber and paid a monthly salary. He was not paid per prescription issued/refused.
- f. The filtered data shows that the Registrant issued:
 - i. A total of 52,347 prescriptions at UK Meds.
 - ii. Total number of prescriptions classified as high-risk controlled: 20 (approx. 0.03%).
 - iii. Total number of prescriptions classified as high-risk not controlled: 5,303 (approx. 10.1%).
 - iv. Total number of prescriptions classified as not high-risk: 47,024 (approx. 89.8%).
- g. By filtering the spreadsheet using the “consent” column accordingly, the data showed:
 - i. Consent given by patient to contact GP: 17,334 times (approx. 33.1% of all prescriptions issued).
 - ii. No consent given by the patient to contact GP: 32,997 times (approx. 63% of all prescriptions issued).
 - iii. Consent to contact GP not asked for: 2,016 times (approx. 3.9% of all prescriptions issued).
- h. By filtering the spreadsheet using the “has_gp_ticket” column accordingly, the data for whether the GP was actually contacted showed:
 - i. Number of times the GP was contacted (has GP ticket): 3,712 times (approx. 7% of all prescriptions issued).

- ii. Number of times the GP was not contacted (does not have GP ticket):
48,635 times (approx. 92.9% of all prescriptions issued).
- i. For all prescriptions issued for high-risk not controlled medications, if a patient did not give consent for their GP to be contacted, or if consent was not asked for, the Registrant did not raise a ticket and contact the GP.
- j. For all prescriptions issued for high-risk not controlled medications where a patient gave consent for their GP to be contacted (1,721 times), the Registrant only contacted the GP 418 times. This equates to approximately 24.2%.
- k. In the spreadsheet "Obeng Prescribing Data – Halliwell Pharmacy – With Customer Name Removed". There was a total of 14,652 rows in the spreadsheet. The spreadsheet showed:
 - i. Number of prescriptions "shipped": 11,047. There were four additional prescriptions that were shipped, bringing the total number of shipped prescriptions to 11,051.
 - ii. Number of prescriptions "declined by doctor": 1,509.
 - iii. Number of prescriptions "declined by pharmacy": 2,089.
 - iv. Number of prescriptions "declined by you" (Superintendent of Halliwell):
1
 - v. Total number of prescriptions classified as high-risk not controlled: 2,920 (approx. 22.2%).
 - vi. Total number of prescriptions classified as not high risk: 10,217 (approx. 77.7%).
- l. When Halliwell was asked *"Do you have access to a total figure of how many letters to GPs that Mr Obeng sent?"*, the Council received the response:
"Unfortunately, our system currently does not support the feature to pull the total number of letters sent to GPs. I can confirm that while Mr. Obeng was with us, our system automatically sent letters to GPs, provided that consent was given."

- m. The Registrant issued a total of 2,960 prescriptions via PillDoctor between 3 August 2021 and 10 June 2022. There were 237 prescriptions issued by the Registrant where a GP name was provided by the patient. This equates to approximately 8% of all prescriptions issued by the Registrant. The Registrant prescribed a total of 2,659 prescriptions for weight loss medications. This is approximately 89.8% of all prescriptions issued by the Registrant.
- n. The Council received further information which has impacted FV's previous reviews of disclosure provided by UK Meds.
- o. Because there was an issue with the timing of the prescriptions from the data provided by Meds UK, the Spreadsheets removed all references to timings. FV does not know whether the issue concerning timing has undermined the data provided by UK Meds, but this would not impact upon the rest of the information provided by UK Meds. FV was aware that Mr S, a Director of UK Meds, considered any issue concerning timing "*could be a bug*".
- p. FV does not think that the data provided by UK Meds has any flaws or glitches, but she does not know how UK Meds ran or how it input information to create the data provided.
- q. FV did not scrutinise the underlying data provided by UK Meds; she understands this was used to make the Spreadsheets.
- r. FV does not know why there are over 2000 entries without a customer number.
- s. FV does not know why approximately half of the entries do not have a "cscart_order_id".
- t. The source of FV's analysis of each patient's prescription came from the Spreadsheets and MA' statement. Although FV did not have the patient's medical records, she had their questionnaires.

67. The Committee received oral evidence from NR who stated the following:

- a. NR went to investigate Pharmacorp rather than any particular individual working at Pharmacorp. She only visited Pharmacorp once.
- b. NR is unaware whether a pharmacist would have had access to both the front end and back end of Pharmacorp's computer systems; she is unaware if the pharmacist would have been able to see, and she is unaware whether the pharmacist would have had sight as to whether any answers would have been changed by the patient. However, it would be the responsibility of a pharmacist or a prescriber to raise a request for any information that they could not see.
- c. During the investigation into Pharmacorp, the Registrant was open and honest with his answers.
- d. NR's notes from the visit set out that the consultation was *"Questionnaire based"*. If a patient provided a response to a question which prevented them from obtaining the medicine, this would be highlighted with a message, *"Unable to continue based on this selection please contact our support team"*. The patient could then change their answer and proceed with the order. It was possible for responses to be changed by patients in order to obtain a prescription and supply.
- e. NR's notes from the visit set out that the Prescriber SOP: *"Provides information on how an order is received states that on completing initial part of questionnaire, a list of medication will be available to the patient which they can chose."*
- f. There were circumstances at Pharmacorp where letters were not sent to GPs, even when the patients gave their consent to send the letter to their respective GPs. A Director at Pharmacorp said that there were systems in place for a patient's GP to be contacted by telephone or letter, but this was done by exception, not routine. This same Director was responsible for sending letters out to GPs when a patient consented. Consent is a fundamental tenet of all clinical practice. If there is no consent, then the patient's GP should not be contacted.

- g. NR provided an example at Pharmacorp where there was no documented reason for propranolol being prescribed.
- h. After the inspection, the Council requested further prescriptions and patient consultations from Pharmacorp. Many issues were identified with these supplies, including instances where patients had not consented to their GP being contacted regarding the supply of treatment and poor/a lack of recording of prescribing rationale. In cross examination, NR confirmed that further prescriptions and patient consultations related to prescriptions that pre-dated 6 April 2022.
- i. On 4 October 2023, NR was asked by MA, Professionals Regulations Manager at the Council's Fitness to Practise team, to categorise medicines from spreadsheets of prescription data that she had received from UK Meds. MA asked NR and AO, who was at the time employed by the Council as a Chief Pharmaceutical Officer's Clinical Fellow and Specialist Inspector, to support the categorisation of medicines into groups to identify which medicines were of higher risk and/or liable to abuse, misuse and overuse:
 - i. SO combined all the entries of all medication provided by UK Meds ("SO/1"). Nothing was removed from these spreadsheets. SO split tabs so that medicines were not repeated.
 - ii. In NR/04, NR listed medicines from the spreadsheet which she considered to be of higher risk and/or liable to abuse, misuse and overuse. The left column contained controlled drugs of schedule 3, 4 and 5. These included opioids, benzodiazepines, Z drugs (used for insomnia) and anticonvulsants (pregabalin and gabapentin).
 - iii. Controlled drugs require a higher level of regulation and can be especially addictive. NR considered these to be of higher risk and liable to abuse misuse and overuse. Due to their addictive properties, there is an increased risk of overuse which can lead to overdoses. These can be fatal with opioids which include but are not limited to codeine, co-codamol and dihydrocodeine and benzodiazepines which include but are not

limited to diazepam and flurazepam. Overdose with these medicines can lead to respiratory depression and coma.

iv. In the column on the right-hand side in NR/04, NR included other medicines which she did not necessarily consider to be habit forming or liable to abuse, misuse or overuse. However, she believed that these medications had a potential to pose a risk to a person/patient in certain situations and circumstances. Examples of reasons why a medication may have been added to this column include but are not limited to:

1. a patient's demographics may increase the risk posed to them by the prescribed medication.
2. requirement for ongoing monitoring, follow-up and management of patients obtaining medications for conditions such as asthma and diabetes, which may be more difficult to achieve when prescribing remotely.
3. increased risks due to drug interactions or comorbidities.
4. medications where safeguarding considerations may play a part in a prescriber's decision making such as medications for the treatment of sexually transmitted diseases.
5. Where physical/ face to face consultation may support a prescriber's decision making.

j. NR has not seen data specific to the Registrant's prescribing.

k. SO/1 included pharmacy general sale items, p-medicines and non-medicinal items, which would have come across a prescriber's path.

l. NR did not conduct an analysis of spreadsheet SO/1.

68. The Committee received oral evidence from SO who stated the following:

- a. SO combined the data from 32 spreadsheets provided by UK Meds together to create one single master spreadsheet containing 877,891 rows of data ("SO/1"). SO/1 contains all the information provided to the Council by UK Meds. SO/1 did not delete any data provided by UK Meds.
- b. The titles in the original data were not touched, but extra columns were added. He knew what the titles used for the analysis meant. SO was trying to give the case officers what they wanted from the data.
- c. As he did not create the raw data received from UK Meds, SO does not know why approximately 2000 entries had no customer ids and why half of cscart bank entries were blank.
- d. SO's role was to work with the data that was there and he would not have tampered with that data. The data from the 32 spreadsheets were CSV files, openable in Excel. No patient data was provided.
- e. SO was not tasked to analyse the data, but to prepare it. Any analysis would have been done by a case officer.
- f. SO was not aware of any anomalies in the data, although there were gaps in the data. However, it was not his role to fix the gaps in the data provided by UK Meds.
- g. Following the drafting of his statement, SO was never given any information about the discrepancy with the timings of UK Meds prescribed medicines.

69. The Committee received oral evidence from MA who stated the following:

- a. At the time of the investigation into UK Meds, MA dealt with the majority of the UK Meds cases. She was coordinating the investigations, including the disclosure requests, responses to which were being sent in a piecemeal fashion. She started with the investigation into UK Meds and then moved to individuals. MA would get direction from Principal Lawyers if she needed it.
- b. On 24 January 2022, the Council received disclosure in two parts.

- c. On 14 February 2022, MA wrote again to the Directors of UK Meds, outlining the disclosure that remained outstanding. MA also wrote with queries following the disclosure received on 24 January 2022 and with new requests for disclosure.
- d. On 14 September 2022, the Council received disclosure which included a witness statement of a Director of UK Meds together with an exhibit which were written for separate proceedings that related to the Council's application for a court order for disclosure under Article 49(4) of the Pharmacy Order 2010. Also provided on this date were excel spreadsheets relating to a number of prescribers. These were superseded with more complete disclosure on 11 October 2022.
- e. On 11 October 2022, following an Order from the County Court requiring disclosure, the Council received disclosure from the directors of UK Meds via their legal representative. Following this disclosure, MA considered the Council had everything that it needed. These included spreadsheets relating to a number of prescribers and their prescriptions at UK Meds, including the Registrant. By email of 17 October 2022, MA asked SO, Senior Data Analyst and Insight Manager at the Council, to combine the entirety of the spreadsheets into one master spreadsheet ("SO/1").
- f. Only FV was tasked with analysing SO/1 for the Registrant. Each case would have a different case officer analysing information. MA did not analyse any document, but was on standby should a case officer have had any questions.
- g. The County Court order was limited to what was requested, including, where appropriate the clinical care records of patients. It would not have been proportionate to request the clinical records of all UK Meds patients.

70. The Committee received oral evidence from Dr C who stated the following:

- a. A prescriber is responsible for checking medication and whether this aligns with the patient's needs and patient history.

- b. Many of the medicines requested by prescription from online pharmacy customers are high risk medications which should raise a red flag to the prescriber. A prescriber should check whether the patient regularly receives such medication from their GP, whether they might be an addict or whether the medication is being obtained under duress.
- c. If medication is needed in an emergency, a patient also has the option to use a walk-in clinic or an out of hours clinic.
- d. Patients know that, when obtaining a prescription from an online pharmacy, if they tick that they have mental health problems or addiction problems, the process ends. Therefore, the questionnaire process may not be safe. Questionnaires become bad when they are the only information relied upon and the information contained within them is self-reporting from the patient, especially where the patient opts out of their GP being contacted.
- e. POM would need a patient review, for example, a blood review, a blood pressure review, a physiotherapy review. There is a danger to the health of an individual if POM is not used correctly. If a patient is a diabetic or has an underlying health condition, prescribing may only be safe if there is a patient review.
- f. A review for any medication is also important where a patient has an allergy to different types of medication. If medication is prescribed without knowing a patient's history, this can be dangerous, even if the medication appears innocuous.
- g. Over the Counter ("OTC") medication can be bought safely and a review is not usually needed. However, a patient will receive some advice from a pharmacist when buying such medication from a pharmacy, and whether there are any other medicines a patient is taking. A duty of care is owed by a pharmacist, which is different from a supermarket worker at a supermarket which sells OTC medicines.
- h. A face-to-face consultation is not needed for every patient. For example, if there is a regular patient whom the doctor knows, then there may not be a need to see that patient face-to-face prior to a prescription.

- i. Dr C does not disagree with the pros and cons from the Registrant's Dissertation Project.

Half-time submission

- 71. On behalf of the Registrant, Mr Smalley made submissions at the end of the Council's case that the Council has not provided any evidence in relation to allegations 1.3, 2.2, 6.1, 6.2 and 6.4.
- 72. Concerning allegations 1.3 and 2.2, Mr Smalley submitted that:
 - a. The allegations have been poorly drafted, and the words "*around, or up to*" is unclear.
 - b. It is unclear what is meant by "*not high-risk and or habit forming medicine*".
 - c. There has been no evidence going to these two allegations. The four categories of medication include POMs, pharmacy general sale items, pharmacy only medicines, and non-medicinal items. These items have not been separated out in SO/1 to see if they are habit forming or not, or whether or not they require a review or not. Evidence is needed to place them into a category that indicates whether this medication is habit forming or not, or whether a review is required.
- 73. Concerning allegations 6.1, 6.2 and 6.4, Mr Smalley submitted that there is no evidence within the time period 6 April 2022 to 6 June 2022, and therefore no evidence in relation to these allegations concerning allegation 4.
- 74. In response, Mr Wigg submitted:
 - a. If an allegation is unclear or ambiguous, the Committee can amend the allegation.
 - b. Allegations 1.3 and 2.2 is capable of proof. A partial admission had been made by the Registrant, where the only live issue is one of the number of items.
 - c. The categorisation of the medicines in SO/1 is a non-issue. Allegations 1.3 and 2.2 do not require categorisation. The medicines covered by this allegation is

covered by the categorisations “*not high risk*” and/or “*habit forming*”. Anything within these categorisations is caught by allegations 1.3 and 2.2. Neither FV’s nor SO’s evidence on this point was challenged by the Registrant.

- d. In relation to allegations 6.1, 6.2 and 6.4, allegation 4 had been admitted by the Registrant; therefore, the only issue is that of the prescribing model set out in allegation 6. In relation to the prescribing model:
 - i. The Registrant prescribed for Pharmacorp.
 - ii. Concerning allegation 6.2, the pre-selection of the strength of medicines was flagged in a pre-inspection report (“*Pharmacorp Improvement Action Plan*”, undated) as an issue at 3.1: “*The pharmacy’s website allows people to select a prescription only medicine and quantity before starting a consultation. This does not meet GPhC guidance*” with improvement required by 25 July 2022.
 - iii. Concerning allegation 6.4, allegation 6.3 is admitted, which set out that patients provided information primarily through a questionnaire. Dr C has raised issues about using questionnaires as the main source of obtaining patient information. There is no information to suggest that the questionnaire, or the method to obtain patient information was changed before 6 June 2022.
 - iv. The use of the word “*approximately*” in allegation 4 provides some leeway of the date of prescribing.

Use of Registrant’s evidence

- 75. In his submissions, Mr Wigg made reference to the Registrant’s witness statement and the Dissertation Project. Ms Smalley responded that:
 - a. The Committee is not entitled to take into account the Registrant’s witness statement or the Dissertation Project as this was not part of the Council’s case; and

- b. In any case, the Dissertation Project was immaterial to the half-time submission.
76. In response, Mr Wigg set out that:
- a. Although he cannot find any case on this issue, the Committee should be able to take the Registrant's witness statement into account as it determined how his case was presented; and
 - b. Even without the Registrant's witness statement, there is sufficient evidence for the Registrant's half-time submission to be unsuccessful.
77. The Committee considered the test for a half-time submission, as set out in R v Galbraith [1981] 1 WLR 1039:

"How then should the judge approach a submission of 'no case'?"

(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.

(2) The difficulty arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence.

(a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.

(b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness' 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 upon which a 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.

It follows that we think the second of the two schools of thought is to be preferred. There will of course, as always in this branch of the law, be borderline cases. They can safely be left to the discretion of the judge."

78. The Committee considered the phrase “*the prosecution evidence*” in *Galbraith* meant that any half-time submission should be made solely on the Council’s evidence and the evidence heard in the proceedings. This included:
- a. The Registrant’s admissions;
 - b. The file note from the Council dated 7 August 2024; and
 - c. The Dissertation Report which was admitted into evidence and used when questioning Dr C.
79. It did not include the Registrant’s witness statement as this had not been admitted into evidence as yet.

Second application to amend the particulars of allegation

80. Under Rule 41, the Committee proposed to amend allegations 1.2 and 2.2 as follows (additions in underline and removals in strikethrough):

1.3 Whilst working for UK Meds Direct Ltd between approximately 5 November 2019 and 23 February 2022, you prescribed and, or approved around, or up to 47,024 not high-risk, and/or not habit-forming medicines/non-medicinal items, but may require ongoing monitoring and management.

2.2 Whilst working for Prescription Doctor, connected to Halliwell Midnight Pharmacy between approximately 20 January 2022 and 2 May 2022, you prescribed and or approved around, or up to 10,217 not high- risk, and/or not habit-forming medicines/non-medicinal items, but may require ongoing monitoring and management.

81. The proposed changes provide clarity to the allegations, do not materially amend the allegations, and would not, therefore, prejudice the fairness of the proceedings, given:

- a. The current intention of the allegations is to consider not high-risk and not habit-forming medication given the previous allegations in the same respective sub-sections (1.1, 1.2 and 2.1) refer to high risk medication.
 - b. The wording from this allegation appears to arise from NR exhibit NR/04 which provided a column titled: *“not habit forming but may require ongoing monitoring and management”*.
 - c. The term *“non-medicinal items”* has been added to clarify that some items in the list may be non-medicinal.
 - d. When the allegations were read out to the Registrant, in relation to allegations 1.3 and 2.2, the Registrant narrowed the issues in that the only disputed part of the allegation is that of the number of prescriptions/medicines referred to.
82. On behalf of the Council, Mr Wigg did not oppose the proposed amendments.
83. On behalf of the Registrant, Mr Smalley did not oppose the amendment to both allegations concerning *“not”* habit forming. However, Mr Smalley objected to the addition of *“non-medicinal items”* on the basis that it would cause prejudice to the Registrant given that:
- a. It would widen the scope of allegations 1.3, 2.2, 3, 4, 5 and 6.
 - b. Further, this case relates to the Registrant’s prescribing activity. Non-medicinal items do not:
 - i. require a prescription; and
 - ii. engage misconduct.
- Therefore, this amendment would give rise to further applications of no case to answer.
84. The Committee considered the amendment to add *“not”* habit forming clarifies the allegations which does not materially amend any of the allegations and would, therefore, not prejudice the fairness of the proceedings.

85. However, the Committee considered the amendment to add “*non-medicinal items*” would cause prejudice to the Registrant for the reasons set out by Mr Smalley set out in paragraph 83 above.
86. Consequently, the Committee amended allegations 1.2 and 2.2 as follows (additions in underline and removals in strikethrough):

1.3 Whilst working for UK Meds Direct Ltd between approximately 5 November 2019 and 23 February 2022, you prescribed and, or approved around, or up to 47,024 not high-risk, and/or not habit-forming medicines, but may require ongoing monitoring and management.

2.2 Whilst working for Prescription Doctor, connected to Halliwell Midnight Pharmacy between approximately 20 January 2022 and 2 May 2022, you prescribed and or approved around, or up to 10,217 not high- risk, and/or not habit-forming medicines, but may require ongoing monitoring and management.

Decision on half-time submission

87. The Committee determined that there is a case to answer in relation to allegations 1.3, 2.2, 6.1, 6.2 and 6.4. In relation to each allegation, the Committee considered there to be the following evidence which was not limited or tenuous in character, for the following reasons:

Allegation 1.3 – Whilst working for UK Meds Direct Ltd between approximately 5 November 2019 and 23 February 2022, you prescribed and, or approved around, or up to 47,024 not high-risk, and/or not habit-forming medicines, but may require ongoing monitoring and management

88. SO provided evidence that SO/1 combined the data from 32 spreadsheets provided by UK Meds together to create one single master spreadsheet containing 877,891 rows of data. SO/1 contains all the information provided to the Council by UK Meds. SO/1 did not delete any data provided by UK Meds. The titles in the original data

were not touched, but extra columns were added. SO was not aware of any anomalies in the data, although there were gaps in the data.

89. The filtered data in SO/1 shows that the Registrant issued 47,024 prescriptions classified as *“not high-risk”* between 5 November 2019 and 23 February 2022.
90. NR provided evidence of drugs that she considered to be *“not habit forming but may require ongoing monitoring and management”*. These medicines included Omeprazole, Ventolin, Norethisterone, Azithromycin, and Candesartan, which all appear in the filtered data in SO/1 as prescriptions classified as *“not high-risk”* and prescribed by the Registrant.
91. Dr C provided evidence that a review for any medication is also important where a patient has an allergy to different types of medication. If medication is prescribed without knowing a patient’s history, this can be dangerous, even if the medication appears innocuous. The Committee has taken this to mean that for any type of medication, even those deemed to not be high risk, that for certain patients, ongoing monitoring and management may be required.
92. When the allegations were read out to the Registrant, in relation to allegation 1.3, the Registrant narrowed the issues in that the only disputed part of the allegation is that of the number of prescriptions/medicines referred to.

Alegation 2.2 – Whilst working for Prescription Doctor, connected to Halliwell Midnight Pharmacy between approximately 20 January 2022 and 2 May 2022, you prescribed and or approved around, or up to 10,217 not high-risk, and/or not habit-forming medicines, but may require ongoing monitoring and management

93. In the spreadsheet *“Obeng Prescribing Data – Halliwell Pharmacy – With Customer Name Removed”*, there was a total of 14,652 rows. The spreadsheet showed that the Registrant issued 10,217 prescriptions classified as *“not high risk”* which were not declined by the Registrant between 20 January 2022 and 2 May 2022.
94. NR provided evidence of drugs that she considered to be *“not habit forming but may require ongoing monitoring and management”*. These medicines included

Omeprazole, Ventolin, Norethistorone and Azithromycin, which all appear in the filtered data in *“Obeng Prescribing Data – Halliwell Pharmacy – With Customer Name Removed”* as prescriptions classified as *“not high-risk”* and prescribed by the Registrant.

95. Dr C provided evidence that a review for any medication is also important where a patient has an allergy to different types of medication. If medication is prescribed without knowing a patient’s history, this can be dangerous, even if the medication appears innocuous. The Committee has taken this to mean that for any type of medication, even those deemed to not be high risk, that for certain patients, ongoing monitoring and management may be required.
96. When the allegations were read out to the Registrant, in relation to allegation 2.2, the Registrant narrowed the issues in that the only disputed part of the allegation is that of the number of prescriptions/medicines referred to.

6.1 – In relation to 1, 2, 3 and 4 above, you prescribed in circumstances where the prescribing model or service was incapable of supporting safe prescribing decisions in that no face-to-face or other virtual consultation took place other than the use of a questionnaire

97. The Registrant only brought a submission of no case to answer concerning allegation 4 in relation to allegation 6.1. Allegation 4 concerns the Registrant’s prescribing or approval of prescriptions in relation to Pharmacorp.
98. NR provided evidence that she inspected Pharmacorp on 6 April 2022. Upon arrival of the inspection, the only person present at the pharmacy was the Operations Director, JD. JD confirmed that the Registrant was the only independent prescriber who issued prescriptions at the pharmacy. JD also added that approximately 15 prescriptions were issued per day by the Registrant. The Committee considered this to be evidence that, on at least 6 April 2022, the Registrant was issuing prescriptions as set out NR’s notes from the visit.

99. NR provided evidence that she went to investigate Pharmacorp rather than any particular individual working at Pharmacorp. NR's notes from the visit set out that the consultation was *"Questionnaire based"*.
100. NR's notes from the visit set out that the Prescriber SOP: *"Provides information on how an order is received states that on completing initial part of questionnaire, a list of medication will be available to the patient which they can chose."* There is no mention of another type of consultation in NR's notes.

6.2 – In relation to 1, 2, 3 and 4 above, you prescribed in circumstances where the prescribing model or service was incapable of supporting safe prescribing decisions in that patients were allowed to pre-select the medicine, strength, and quantity they desired

101. The Registrant only brought a submission of no case to answer concerning allegation 4 in relation to allegation 6.2. Allegation 4 concerns the Registrant's prescribing or approval of prescriptions in relation to Pharmacorp.
102. NR's notes from the visit set out that the Prescriber SOP: *"Provides information on how an order is received states that on completing initial part of questionnaire, a list of medication will be available to the patient which they can chose."* There is no mention of another type of consultation in NR's notes.
103. The pre-selection of the strength of medicines was flagged in a pre-inspection report (*"Pharmacorp Improvement Action Plan"*, undated) as an issue at 3.1: *"The pharmacy's website allows people to select a prescription only medicine and quantity before starting a consultation. This does not meet GPhC guidance"* with improvement required by 25 July 2022.

6.4 – In relation to 1, 2, 3 and 4 above, you prescribed in circumstances where the prescribing model or service was incapable of supporting safe prescribing decisions in that the questionnaire at 6.3 above could easily be manipulated by patients as it

highlighted to them answers which could prevent the supply of the medication they desired and permit the patient to change their answer.

104. The Registrant only brought a submission of no case to answer concerning allegation 4 in relation to allegation 6.4. Allegation 4 concerns the Registrant's prescribing or approval of prescriptions in relation to Pharmacorp.
105. NR's notes from the visit set out that the consultation gives a: *"Pop up to negative responses to questionnaire."* There is no mention of another type of consultation in NR's notes. In her oral evidence, NR expanded on this point setting out that if a patient provided a response to a question which prevented them from obtaining the medicine, this would be highlighted with a message, *"Unable to continue based on this selection please contact our support team"*. The patient could then change their answer and proceed with the order. It was possible for responses to be changed by patients in order to obtain a prescription and supply.

Registrant's evidence

106. The Registrant gave the following evidence:
- a. He worked for UK Meds, starting on 5 November 2019. His last working day was 29 September 2021. He did not work for UK Meds after this date. He no longer had access to UK Meds' systems after 29 September 2021. In order to log onto UK Meds' systems, he would have a user name and password to log onto the portal, where he would have access to the dashboard and patient data.
 - b. At UK Meds, he worked 35 hours per week, all remotely. He worked 7.30am to 9.30am and 5pm to 10pm. He also worked at Wellspring Pharmacy (in person) 6 hours a week on a Friday. He has approximately 6 weeks of annual leave
[PRIVATE].
 - c. As he no longer had access to UK Meds' systems, he was not responsible for the prescription dated 23 February 2022 set out in SO/1. He cannot identify any other prescriptions which he was not responsible for in SO/1 as he no longer has access to UK Meds' systems.

- d. Similarly, he has no access to the data/portal of Prescription Doctor, Pill Doctor and Pharmacorp since he left working for them.
- e. His last working day for Pill Doctor was 6 June 2022 as it was on this date that he received notification from the Council about an interim order. **[PRIVATE]**
- f. At UK Meds, there was no facility to have a face-to-face consultation with patients. He could communicate with patients through messaging and email. There would be a log of previous communications. UK Meds also had internal communications.
- g. At Pill Doctor, Prescription Doctor and Pharmacorp, there was no facility to have a face-to-face consultation with patients. He could communicate with patients through telephone consultations. He could also make and receive photo requests. The Responsible Pharmacist and administrative staff (call handlers) could communicate with patients if there was any missing information. He could request further information from specialists.
- h. The purpose of any consultation, which included questionnaires, was to gather as much information as possible to decide on the next course of action for the patient. The next actions could include prescribing (if there was sufficient information), reject the prescription, request further information, or refer the patient to a specialist/their GP. A source of information, such as a questionnaire, is only a part of the journey of a consultation. The process of starting information does not need to start with a face-to-face consultation.
- i. At UK Meds, an automatic IT system would inform the patient's GP where required, if the patient had consented. The Registrant's role was to focus on the consultation and the IT system would deal with patient contact and GP contact. There was a dedicated team for sending letters to GPs.
- j. Similarly, at Prescription Doctor, Pill Doctor and Pharmacorp, where patients had consented to their GP being contacted, the Registrant's role was to focus on the consultation and the admin team (through the IT system) would deal with patient contact and GP contact.

- k. He did not consider there to be an obligation upon himself to inform a patient's GP. This would be done by the supporting team as part of the wider pharmacy. He trusted the systems when working at UK Meds, Prescription Doctor, Pill Doctor and Pharmacorp.
- l. Where patients did not give consent to contact their GP, there was a challenge around a patient's right to consent. Patients had to make a choice. At UK Meds, the Registrant was unsure what happened when patients did not give their consent for their GP to be contacted.
- m. At Prescription Doctor, he had help from Dr G; a physical member of staff that he could speak to get further information and further clarification.
- n. He referred patients back to their GP on a regular occurrence.
- o. If there is no face-to-face or virtual consultation, this does not make the service incapable of supporting safe prescribing decisions. It may be more appropriate to have a telephone consultation or a face-to-face consultation depending on the condition.
- p. At UK Meds, Pill Doctor, Prescription Doctor and Pharmacorp, prescribers did not have access to the front end of the system. The front end of the system was where the patient input answers to questionnaires. Prescribers only had access to the back-end of the system, where they could see the answers to the questions posed, the order history and previous communications between the pharmacy and the patient. The Registrant was never shown the front end of the system (even during inductions) and was not curious to check out the front end of the systems himself.
- q. At UK Meds, Pill Doctor, Prescription Doctor and Pharmacorp, there were cases where patients pre-selected the medicines, strength and quantity desired. However, what the patient wanted was not part of the prescribing decision. This information did not affect the Registrant's decision making.
- r. He was not informed of the patient's ability to change answers at the front end of the system. However, where an answer has been changed, at UK Meds, there

may be an indication at the back end of the system through colour coding or a change in font. However, he was not aware of the reason for the change. The Registrant never considered accessing the front end of the system at any of the pharmacies as there was a dedicated team looking after the front end of the system, and it was not something that crossed his mind.

- s. In a reflective piece dated 2 April 2026, the Registrant set out, in relation to UK Meds: “[the workplace culture and leadership challenges] *created a sustained sense of pressure, where I felt that my professional judgment was being challenged in a way that made it difficult to practise with confidence.*” In cross examination, the Registrant explained that the pressure in workplace was from a combatant style of communication. He was free to make his own prescribing decisions. He faced no direct consequence to refuse prescriptions or request more information. There was, however, scrutiny of his decisions afterwards. Even with knowledge that there was scrutiny post-decision making, the Registrant felt he was free to make his own decisions.
- t. He was not working at UK Meds on 23 February 2022, so he is unsure how this date came to be in SO/1. This raises a larger issue as to how information was gathered from UK Meds, and how accurate this information is.
- u. He did not keep a tally of the number of prescriptions he issued when working at UK Meds, Pill Doctor, Prescription Doctor or Pharmacorp.
- v. He admitted to allegation 2.1 as there was no discrepancy with the data.
- w. He accepted that he prescribed POMs which have not been classified as high risk or habit forming. Some of these will have required ongoing monitoring and management.
- x. He accepted the numbers in FV’s statement that when at Prescription Doctor, he issued 13,137 prescriptions, of which 2,920 prescriptions classified as high-risk not controlled.
- y. He accepted and understood that the lack of face-to-face assessment was inadequate for high-risk and habit-forming medicines. He accepts that for high

risk and habit-forming medicines there is a strong presumption that there should be a face-to-face consultation although one is not necessary in every case of prescribing. Information may be able to be obtained, for example, by telephone. For non-high-risk medicines, he considered at the time that the remote consultations available were adequate. He now knows that even with these medicines there may be occasions where a face-to-face consultation is necessary. A face-to-face consultation may be appropriate where medicines have been refused and a face-to-face consultation may be needed, for example, with the patient's GP. The need for a face-to-face consultation depends on a case-by-case basis. Simply because there is no face-to-face facility does not make it incapable of being a safe consultation.

- z. At the time of the allegations, he did not read Council Guidance in relation to prescribers. His understanding of his obligations came from when he worked in a GP practice. Furthermore, he had a team, including SIs, and system in which he had trust. The guidance included:
 - i. A pharmacist *"will proactively share all relevant information about the prescription with other health professionals involved in the care of the person (for example their GP)"*. The Registrant set out that he had trust in the system and the automation of the wider pharmacy would deal with sharing all relevant important information about the prescription with other health professionals involved in the care of the person.
 - ii. *"Everyone in the pharmacy team, including managers with delegated responsibility and the responsible pharmacist, should understand the guidance and be aware of their responsibilities to follow it."* The Registrant said that he has read the Council's guidance since the time of the allegations.
 - iii. *"In light of the very real patient safety risks, pharmacist prescribers must not make prescribing decisions for high-risk medicines based mainly on online questionnaires with no access to the person's medical history or consent to contact the person's regular prescriber. (High-risk medicines*

are, for example, those liable to abuse, overuse or misuse, or when there is a risk of addiction and ongoing monitoring is important.)” The Registrant explained that his practice at the time was not solely based on questionnaires and would also involve communicating with patients and gathering information from others, including the Patient’s GP and specialists.

- iv. *“If the pharmacist prescriber has not carried out a face-to-face consultation with the person, they should explain to the person how the remote consultation will be carried out.”* The Registrant explained that a remote consultation can be conducted in many ways including a questionnaire.
 - v. *“If a pharmacist prescriber decides to prescribe at a distance or work with an online prescribing service, the above categories of medicines should not be prescribed unless the prescriber: will proactively share all relevant information about the prescription with other health professionals involved in the care of the person (for example their GP) - has contacted the GP in advance of issuing a prescription for medicines which are liable to abuse, overuse or misuse (or where there is a risk of addiction and ongoing monitoring is important) and the GP has confirmed to the prescriber that the prescription is appropriate for the person and that appropriate monitoring is in place”.* The Registrant explained that he did not contact a GP prior to prescribing. The teams at each pharmacy would look after communications with GPs.
- aa. The organisations that he worked for (UK Meds, Pill Doctor, Prescription Doctor and Pharmacorp) complied with the national prescribing guidelines, which are different from the Council’s guidelines and refer to medication and the treating of conditions.
 - bb. Whilst at all the organisations patients could pre-select medicine, strength or quantity. This did not affect his clinical judgement at the time.

- cc. In a reflection the Registrant set out: *“allowing patients to pre-select medications, doses, and quantities undermined the professional responsibility inherent in prescribing. This approach shifted decision-making away from clinician-led judgement towards a more consumer-driven model, which is incompatible with safe clinical practice.”* The Registrant explained that this reflection is to do with the front end of the system. What a patient chooses does not affect the clinical decision that he makes.
- dd. In relation to Patient A, it was not uncommon during that time of year for a patient to request Propranolol because it was exam season, and this would be a prescription for anxiety.
- ee. Prescribing Propranolol could be a sign of a mental health condition.
- ff. Concerning Patient A, at the time, it did not concern the Registrant that Patient A had ticked the box that said she did not have a mental health condition; he considered that he had sufficient information that he needed to inform his decision making. In hindsight, however, the Registrant considered that at least a telephone conversation would have assisted him to provide more information. However, at UK Meds, there was only the facility to communicate through a messaging system.

Decision on Facts

107. The Committee proceeded to determine the non-admitted allegations, those being allegations 1.1, 1.2, 1.3, 2.2, 5.4, 5.6, 6.1, 6.2, 6.4, 7.5.
108. In relation to allegations 1.1, 1.2, 1.3 and 2.2, the Registrant narrowed the issues in that the only disputed part of the allegation is that of the number of prescriptions/medicines referred to in each allegation.
109. When considering each allegation, the Committee bore in mind that the burden of proof rests on the Council and that allegations are found proved based on the

balance of probabilities. This means that allegations will be proved if the Committee is satisfied that what is alleged is more likely than not to have happened.

110. In reaching its decisions on facts, the Committee considered the documentation listed at the start of this determination, the live evidence received and the submissions made by Mr Wigg and Mr Smalley.
111. Prior to considering the allegations, the Committee considered the credibility of document SO/1, given its reliance in the allegations. The Committee determined SO/1 to be credible on the basis that:
 - a. The evidence sets out that the raw data provided by UK Meds for SO/1 was not doctored, edited, or manipulated by the Council:
 - i. SO provided evidence that he combined the data from 32 spreadsheets provided by UK Meds together to create one single master spreadsheet containing 877,891 rows of data, titled SO/1. SO/1 contains all the information provided to the Council by UK Meds. SO/1 did not delete any data provided by UK Meds. This evidence was not disputed by either party and the Committee had no reason to doubt the credibility of SO.
 - b. The raw data provided by UK Meds for SO/1 was through a court order, by lawyers (who have an obligation to assist a court), and supplied with a statement used by the County Court (which would not have been anonymised at the time of the County Court proceedings):
 - i. MA provided evidence that, on 11 October 2022, following an Order from the County Court requiring disclosure, the Council received disclosure from the directors of UK Meds via their legal representative. Following this disclosure, MA considered the Council had everything that it needed. These included spreadsheets relating to a number of prescribers and their prescriptions at UK Meds, including the Registrant. By email of 17 October 2022, MA asked SO to combine the entirety of the spreadsheets into one master spreadsheet, namely SO/1. This evidence was not disputed by

either party and the Committee had no reason to doubt the credibility of MA.

- ii. The Committee has seen a witness statement from an unnamed UK Meds Director disclosing the information required by the Council. The name of this Director has been anonymised from these proceedings, but the individual has been identified as a UK Meds Director. The witness statement was used in County Court Proceedings, where the name would not have been anonymised. The Committee considers this to be cogent and reliable evidence of the disclosure provided by UK Meds to the Council.
- c. The Committee notes the error of the entry of 23 February 2022 attributed to the Registrant. The Committee consider this to be an error given that the Registrant was not working for UK Meds at that time and would not have had access to their systems to create an entry. The Committee has not received any other reason for this entry other than an error.
- d. The Committee notes the File Note of the call between Ms T and Mr S, which took place approximately two years after the raw data was disclosed from UK Meds to the Council. For some aspects of the File Note, it appears that Mr S could not answer the questions put to him, including why in some instances the scan time is before the review time, the review time was before the created time. Mr S has speculated why that may be the case. Due to this speculation and the time period elapsed between this call and the time the raw data was disclosed from UK Meds to the Council, the Committee does not consider this part of the File Note to assist it much to determine the credibility of SO/1. The Committee found the “has GP ticket” explanation helpful to see whether a GP had been contacted.
- e. The Registrant submitted that:
 - i. 2000 entries have no customer number;
 - ii. The meaning of some of the items/headers is unknown; and

- iii. Assumptions have been made from limited data provided from UK Meds.

The Committee considers that this information was not used to create the data used in any of the allegations. Furthermore, the Registrant has only speculated that as a result of these issues, the data provided in SO/1 is unreliable, without providing any further examples or evidence from the data used to create SO/1. The Committee considers that the Registrant's submissions do not invalidate the remaining information provided by UK Meds, which can be used to provide data.

Allegation 1.1: Whilst working for UK Meds Direct Ltd between approximately 5 November 2019 and 23 February 2022, you prescribed and, or approved around, or up to 20 prescriptions for high risk controlled medicines

112. The Committee noted the narrow issue identified in this allegation as that of the number of prescriptions referred to. However, the Committee notes that the Registrant worked for UK Meds between 5 November 2019 and 29 September 2021. It does not consider that the Registrant issued the one prescription on 23 February 2022.
113. The Committee considered the following evidence:
- a. FV's evidence that, using SO/1, the Registrant prescribed 20 prescriptions classified as high-risk controlled.
 - b. The Registrant's evidence that he prescribed a small number of high risk controlled medicines, although he does not know the precise numbers.
114. Given:
- a. FV provided evidence that, using SO/1, the Registrant prescribed 20 prescriptions classified as high-risk controlled;
 - b. The Committee's ability to rely on SO/1, as set out in paragraph 111 above; and
 - c. The Registrant's evidence that he prescribed a small number of high risk controlled medicines, although he does not know the precise numbers;

the Committee considers it more likely than not that the Registrant, whilst working for UK Meds Direct Ltd between approximately 5 November 2019 and 29 September 2021 (which is within the time period specified in allegation 1), prescribed and, or approved around, or up to 20 prescriptions for high risk controlled medicines.

115. Consequently, the Committee finds Allegation 1.1 found proved.

This particular is found proved.

Allegation 1.2: Whilst working for UK Meds Direct Ltd between approximately 5 November 2019 and 23 February 2022, you prescribed and, or approved around, or up to 5,303 high risk non-controlled medicines

116. The Committee noted the narrow issue identified in this allegation as that of the number of prescriptions referred to. However, the Committee notes that the Registrant worked for UK Meds between 5 November 2019 and 29 September 2021. It does not consider that the Registrant issued the one prescription on 23 February 2022.

117. The Committee considered the following evidence:

- a. FV's evidence that, using SO/1, the Registrant prescribed 5,303 prescriptions classified as high-risk not controlled.
- b. The Registrant's evidence that he prescribed high risk not controlled medicines, although he does not know the precise numbers.

118. Given:

- a. FV provided evidence that, using SO/1, the Registrant prescribed 5,303 prescriptions classified as high-risk not controlled;
- b. The Committee's ability to rely on SO/1, as set out in paragraph 111 above; and
- c. The Registrant's evidence that he prescribed prescriptions classified as high-risk not controlled, although he does not know the precise numbers;

the Committee considers it more likely than not that the Registrant, whilst working for UK Meds Direct Ltd between approximately 5 November 2019 and 29 September 2021 (which is within the time period specified in allegation 1), prescribed and, or approved around, or up to 5,303 high risk non-controlled medicines.

119. Consequently, the Committee finds Allegation 1.2 found proved.

This particular is found proved.

Allegation 1.3: Whilst working for UK Meds Direct Ltd between approximately 5 November 2019 and 23 February 2022, you prescribed and, or approved around, or up to 47,024 not high-risk, and/or not habit-forming medicines, but may require ongoing monitoring and management

120. The Committee noted the narrow issue identified in this allegation as that of the number of prescriptions referred to. However, the Committee notes that the Registrant worked for UK Meds between 5 November 2019 and 29 September 2021. It does not consider that the Registrant issued the one prescription on 23 February 2022.
121. The Committee noted that allegation 1.3 ends with “*but may require ongoing monitoring and management*”. The Committee considered that the use of the word “*may*” means that it is optional as to whether the not high-risk and/or not habit forming medicines required ongoing monitoring and management. Therefore, there was no need to further split this category into determining whether the not high-risk and/or not habit forming medicines required ongoing monitoring and management.
122. NR provided evidence of drugs that she considered to be “*not habit forming but may require ongoing monitoring and management*”. These medicines included Omeprazole, Ventolin, Norethisterone, Azithromycin, and Candesartan, which all appear in the filtered data in SO/1 as prescriptions classified as “*not high-risk*” and prescribed by the Registrant.
123. Dr C provided evidence that a review for any medication is also important where a patient has an allergy to different types of medication. If medication is prescribed

without knowing a patient's history, this can be dangerous, even if the medication appears innocuous. The Committee has taken this to mean that for any type of medication, even those deemed to not be high risk, that for certain patients, ongoing monitoring and management may be required.

124. The Committee noted that the prescription attributed to the Registrant on 23 February 2022, which could not have been issued by the Registrant given that he was no longer working for UK Meds or had access to their systems, was a not high risk medication. This would bring the number prescribed by the Registrant down to 47,023. However, as the allegation reads "*you prescribed and, or approved around, or up to 47,024...*", the Committee considers this not be material to the allegation.
125. The Committee considered the following evidence:
 - a. FV's evidence that, using SO/1, the Registrant prescribed 47,024 prescriptions classified as not high-risk.
 - b. The Registrant's evidence that he prescribed POMs which have not been classified as high risk or habit forming, although he does not know the precise numbers.
126. Given:
 - a. That the use of the word "*may*" means that that it is optional as to whether the not high-risk and/or not habit forming medicines required ongoing monitoring and management;
 - b. FV provided evidence that, using SO/1, the Registrant prescribed 47,024 prescriptions classified as not high-risk;
 - c. The Committee's ability to rely on SO/1, as set out in paragraph 111 above; and
 - d. The Registrant's evidence that he prescribed POMs which have not been classified as high risk or habit forming;

the Committee considers it more likely than not that the Registrant, whilst working for UK Meds Direct Ltd between approximately 5 November 2019 and 29 September 2021 (which is within the time period specified in allegation 1), prescribed and, or

approved around, or up to 47,024 not high-risk, and/or not habit-forming medicines, but which may require ongoing monitoring and management.

127. Consequently, the Committee finds Allegation 1.3 found proved.

This particular is found proved.

Allegation 2.2: Whilst working for Prescription Doctor, connected to Halliwell Midnight Pharmacy between approximately 20 January 2022 and 2 May 2022, you prescribed and or approved around, or up to 10,217 not high-risk, and/or not habit-forming medicines, but may require ongoing monitoring and management

128. The Committee noted the narrow issue identified in this allegation as that of the number of prescriptions referred to. The Registrant has not disputed that he worked for Prescription Doctor between approximately 20 January 2022 and 2 May 2022.
129. The Committee noted that allegation 2.2 ends with *“but may require ongoing monitoring and management”*. The Committee considered that the use of the word *“may”* means that it is optional as to whether the not high-risk and/or not habit-forming medicines required ongoing monitoring and management. Therefore, there was no need to further split this category into determining whether the not high-risk and/or not habit-forming medicines required ongoing monitoring and management.
130. NR provided evidence of drugs that she considered to be *“not habit forming but may require ongoing monitoring and management”*. These medicines included Omeprazole, Ventolin, Norethisterone and Azithromycin, which all appear in the filtered data in *“Obeng Prescribing Data – Halliwell Pharmacy – With Customer Name Removed”* as prescriptions classified as *“not high-risk”* and prescribed by the Registrant.
131. Dr C provided evidence that a review for any medication is also important where a patient has an allergy to different types of medication. If medication is prescribed without knowing a patient’s history, this can be dangerous, even if the medication appears innocuous. The Committee has taken this to mean that for any type of

medication, even those deemed to not be high risk, that for certain patients, ongoing monitoring and management may be required.

132. The Committee considered the following evidence:
- a. FV' evidence that, using the spreadsheet "*Obeng Prescribing Data – Halliwell Pharmacy – With Customer Name Removed*", the Registrant prescribed 10,217 prescriptions classified as not high-risk.
 - b. "*Obeng Prescribing Data – Halliwell Pharmacy – With Customer Name Removed*". No party has taken an issue with the spreadsheet and the Committee considered it had no information to doubt the credibility of this spreadsheet;
 - c. The Registrant's evidence that he prescribed POMs which have not been classified as high risk or habit forming, although he does not know the precise numbers; and
 - d. The Registrant accepted the numbers in FV's statement that, when at Prescription Doctor, he issued 13,137 prescriptions, of which 2,920 prescriptions classified as high-risk not controlled. Further, the Registrant admitted this at allegation 2.1.
133. Given:
- a. That the use of the word "*may*" means that that it is optional as to whether the not high-risk and/or not habit forming medicines required ongoing monitoring and management;
 - b. FV provided evidence that, using the spreadsheet "*Obeng Prescribing Data – Halliwell Pharmacy – With Customer Name Removed*", the Registrant prescribed 10,217 prescriptions classified as not high-risk;
 - c. The Committee's ability to rely on "*Obeng Prescribing Data – Halliwell Pharmacy – With Customer Name Removed*";
 - d. The Registrant's evidence that he prescribed POMs which have not been classified as high risk or habit forming; and

- e. The Registrant's admission at allegation 2.1 and acceptance of FV's statement that, when at Prescription Doctor, he issued 13,137 prescriptions, of which 2,920 prescriptions classified as high-risk not controlled. By deduction, this left 10,217 prescriptions classified as not high risk;

the Committee considers it more likely than not that the Registrant, whilst working for Prescription Doctor, connected to Halliwell Midnight Pharmacy between approximately 20 January 2022 and 2 May 2022, prescribed and or approved around, or up to 10,217 not high-risk, and/or not habit-forming medicines, but may require ongoing monitoring and management.

134. Consequently, the Committee finds Allegation 2.2 found proved.

This particular is found proved.

Allegation 5.4: In relation to 1, 2, 3 and 4 above, you failed to prescribe medicines in accordance with and/ or pay due regard to the relevant guidance on prescribing from the GMC, the RPS and/ or the Council in that you prescribed in circumstances where you failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication

135. The Committee notes that allegations 1-4 have either been admitted or proved. The Committee notes that at none of the pharmacies set out in allegations 1-4 was there the facility to have face-to-face consultations.

136. The Committee has considered the following evidence:

- a. The Registrant's evidence that at the time of the allegations, he did not read Council Guidance in relation to prescribers. He had a team, including SIs, and system in which he had trust. The guidance included:

- i. *"Everyone in the pharmacy team, including managers with delegated responsibility and the responsible pharmacist, should understand the guidance and be aware of their responsibilities to follow it."* The Registrant said that whilst he had not read the Council's guidance before

or at the time of the allegations, he has confirmed that he has now read the Council's guidance.

- ii. *"If the pharmacist prescriber has not carried out a face-to-face consultation with the person, they should explain to the person how the remote consultation will be carried out."* The Registrant explained that a remote consultation can be conducted in many ways including a questionnaire.
- iii. *"In light of the very real patient safety risks, pharmacist prescribers must not make prescribing decisions for high-risk medicines based mainly on online questionnaires with no access to the person's medical history or consent to contact the person's regular prescriber. (High-risk medicines are, for example, those liable to abuse, overuse or misuse, or when there is a risk of addiction and ongoing monitoring is important.)"* The Registrant explained that his practice at the time was not solely based on questionnaires and would also involve communicating with patients and gathering information from others, including the Patient's GP and specialists.

- b. The Registrant's evidence that he accepts and understands that the lack of face-to-face assessment was inadequate for high-risk and habit-forming medicines. He accepts that for high risk and habit-forming medicines there is a strong presumption that there should be a face-to-face consultation although one is not necessary in every case of prescribing.
- c. At UK Meds, the Registrant prescribed approximately 5,323 high risk medicines.
- d. At Prescription Doctor, the Registrant prescribed approximately 2,920 high risk medicines.
- e. Dr C's evidence that a face-to-face consultation is not needed for every patient. For example, if there is a regular patient whom the doctor knows, then there may not be a need to see that patient face-to-face prior to a prescription.

137. Given:

- a. The Committee has not seen any evidence that the Registrant explained to a patient how the remote consultation will be carried out;
- b. The Registrant did not pay due regard to the relevant guidance on prescribing as he had not read the Council's guidance at the time;
- c. The number of high risk medicines that the Registrant has prescribed from an online pharmacy (over 8,000 over two pharmacies), neither of which had the facility for a face-to-face consultation, or had access to a patient's medical history (other than the history with that particular pharmacy);
- d. The Registrant's admission at allegation 5.2 that he relied principally on the information received in an online questionnaire; and
- e. The Registrant's reliance on other staff at the pharmacies to adhere to relevant guidance;

the Committee considers it more likely than not that, in relation to allegations 1, 2, 3 and 4 above, the Registrant failed to prescribe medicines in accordance with and/or pay due regard to the relevant guidance on prescribing from the GMC, the RPS and/ or the Council in that he prescribed in circumstances where he failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication.

138. Consequently, the Committee finds Allegation 5.4 found proved.

This particular is found proved.

Allegation 5.6: In relation to 1, 2, 3 and 4 above, you failed to prescribe medicines in accordance with and/ or pay due regard to the relevant guidance on prescribing from the GMC, the RPS and/ or the Council in that you prescribed in circumstances where you failed to refer patients back to their GP for appropriate assessment and/ or review and/ or monitoring

139. The Committee has considered the following evidence:

- a. The Registrant's evidence that at the time of the allegations, he did not read Council Guidance in relation to prescribers. He had a team, including SIs, and system in which he had trust. The guidance included:
- i. A pharmacist *"will proactively share all relevant information about the prescription with other health professionals involved in the care of the person (for example their GP)"*. The Registrant set out that he had trust in the system and the automation of the wider pharmacy team, who would deal with sharing all relevant important information about the prescription with other health professionals involved in the care of the person.
 - ii. *"Everyone in the pharmacy team, including managers with delegated responsibility and the responsible pharmacist, should understand the guidance and be aware of their responsibilities to follow it."* The Registrant said that he has read the Council's guidance since the time of the allegations.
 - iii. *"If a pharmacist prescriber decides to prescribe at a distance or work with an online prescribing service, the above categories of medicines should not be prescribed unless the prescriber: will proactively share all relevant information about the prescription with other health professionals involved in the care of the person (for example their GP) - has contacted the GP in advance of issuing a prescription for medicines which are liable to abuse, overuse or misuse (or where there is a risk of addiction and ongoing monitoring is important) and the GP has confirmed to the prescriber that the prescription is appropriate for the person and that appropriate monitoring is in place"*. The Registrant explained that he did not contact a GP prior to prescribing. The admin teams at each pharmacy would look after communications with GPs.
- b. The Registrant never contacted a patient's GP directly. All the online pharmacies set out in the allegations had a separate system to contact the patient's GP.

- c. The Registrant's evidence that the systems at all the pharmacies did not routinely ensure direct conversations with patients to confirm follow up reviews with their GP and where medicines were prescribed, the patient would receive information about following up with their treating clinician.
- d. FV provided evidence that for the Registrant's prescriptions at UK Meds, the GP was not contacted 48,635 times (approx. 92.9% of all prescriptions issued).
- e. FV provided evidence that for the Registrant's prescriptions at Prescription Doctor, the patient's GP was contacted 418 times for high risk not controlled items approximately 24.2% of prescriptions issued).
- f. The Registrant's evidence that at Prescription Doctor, he had help from Dr G; a physical member of staff that he could speak to get further information and further clarification.

140. Given that:

- a. Contacting a patient's GP is a pharmacist's personal responsibility which cannot be delegated to other areas of a pharmacy or to a patient by telling them to follow up with their treating clinician;
- b. The number of prescriptions, including for high risk medication (liable to abuse), issued by the Registrant after which the GP was not contacted;
- c. The Registrant did not pay due regard to the relevant guidance on prescribing as he had not read the Council's guidance at the time;
- d. The Registrant's reliance on other staff at the pharmacies to contact a patient's GP; and
- e. Dr G not being the GP of any of the Registrant's patients;

the Committee considers it more likely than not that, in relation to allegations 1, 2, 3 and 4 above, the Registrant failed to prescribe medicines in accordance with and/or pay due regard to the relevant guidance on prescribing from the GMC, the RPS and/or the Council in that he prescribed in circumstances where he failed to refer patients back to their GP for appropriate assessment and/ or review and/ or monitoring.

141. Consequently, the Committee finds Allegation 5.6 found proved.

This particular is found proved.

Allegation 6.1: In relation to 1, 2, 3 and 4 above, you prescribed in circumstances where the prescribing model or service was incapable of supporting safe prescribing decisions in that no face-to-face or other virtual consultation took place other than the use of a questionnaire

142. For the reasons set out in paragraph 98, the Committee considered there to be evidence in relation to allegation 4 that, on at least 6 April 2022, the Registrant was issuing prescriptions at Pharmacorp.

143. The Committee has considered the following evidence:

- a. None of the pharmacies had the facilities to have face-to-face or virtual consultations. Prescription Doctor, Pill Doctor and Pharmacorp had the facilities to have telephone consultations.
- b. The Registrant has set out that he now accepts that the absence of face-to-face consultation or virtual consultation does not support safe prescribing in most circumstances, but not all.
- c. UK Meds, Prescription Doctor (connected to Halliwell), Pill Doctor (connected to Aktive Pharmacy) and Pharmacorp, all had conditions on their registrations when the Registrant worked there, or prior to the Registrant joining to work there. Due diligence from the Registrant should have informed him of the risks posed by the prescribing practices/models of these pharmacies.
- d. At UK Meds, the Registrant prescribed approximately 5,323 high risk medicines.
- e. At Prescription Doctor, the Registrant prescribed approximately 2,920 high risk medicines.

144. Given that:

- a. None of the pharmacies had the facilities to have face-to-face or virtual consultations;

- b. The Registrant has set out that he now accepts that the absence of face-to-face consultation or virtual consultation does not support safe prescribing in most circumstances, but not all;
- c. The knowledge that the Registrant should have had about the risks posed by the prescribing practices/models of these pharmacies;
- d. The Registrant's admission at allegation 5.2 that he relied principally on the information received in an online questionnaire; and
- e. The number of high risk medicines that the Registrant has prescribed from an online pharmacy (over 8,000 over two pharmacies), neither of which had the facility for a face-to-face consultation, or had access to a patient's medical history (other than the history with that particular pharmacy);

the Committee considers it more likely than not that the Registrant prescribed in circumstances where the prescribing model or service was incapable of supporting safe prescribing decisions in that no face-to-face or other virtual consultation took place other than the use of a questionnaire.

145. Consequently, the Committee finds Allegation 6.1 found proved.

This particular is found proved.

Allegation 6.2: In relation to 1, 2, 3 and 4 above, you prescribed in circumstances where the prescribing model or service was incapable of supporting safe prescribing decisions in that patients were allowed to pre-select the medicine, strength, and quantity they desired

146. The Committee has considered the following evidence:
- a. The Registrant's evidence that whilst at all the organisations patients could pre-select medicine, strength or quantity, this did not affect his clinical judgement at the time. However, the Registrant appears to contradict this evidence in a reflective piece from 2026 in which he states: *"Additionally, allowing patients to pre-select medications, doses, and quantities undermined the professional*

responsibility inherent in prescribing. This approach shifted decision-making away from clinician-led judgement towards a more consumer-driven model, which is incompatible with safe clinical practice.” Although the Registrant explained that this reflection is to do with the front end of the online pharmacy system, to the Committee, the Registrant’s two statements appear contradictory.

- b. The Registrant’s evidence that at the time of the allegations is he did not read Council Guidance in relation to prescribing at a distance. Council Guidance from April 2019 sets out: *“We expect you to make sure that your website and the websites of companies you work with are arranged so that a person cannot choose a POM and its quantity before there has been an appropriate consultation with a prescriber.”* The Registrant said that he did not see the front end of the system.

147. Given:

- a. The clear Council guidance that prescribers for online pharmacies are expected to ensure that the pharmacy’s website does not allow a patient to choose a POM and its *quantity before there has been an appropriate consultation with a prescriber*;
- b. The Registrant’s evidence that at the time of the allegations, he did not read Council Guidance in relation to prescribers; and
- c. The Registrant’s reflection that *“allowing patients to pre-select medications, doses, and quantities undermined the professional responsibility inherent in prescribing. This approach shifted decision-making away from clinician-led judgement towards a more consumer-driven model, which is incompatible with safe clinical practice.”*;

the Committee considers it more likely than not that the Registrant prescribed in circumstances where the prescribing model or service was incapable of supporting safe prescribing decisions in that patients were allowed to pre-select the medicine, strength, and quantity they desired.

148. Consequently, the Committee finds Allegation 6.2 found proved.

This particular is found proved.

Allegation 6.4: In relation to 1, 2, 3 and 4 above, you prescribed in circumstances where the prescribing model or service was incapable of supporting safe prescribing decisions in that the questionnaire at 6.3 above could easily be manipulated by patients as it highlighted to them answers which could prevent the supply of the medication they desired and permit the patient to change their answer

149. The Committee has considered the following evidence:

a. For UK Meds, the inspection report from 2019 set out:

“If a person gave an answer which meant it was inappropriate for them to have the medicine, the following box appeared ‘Based on the answer you’ve given us, it would be best for you to consult your GP or specialist. You are unable to continue.’ The person could then change their answer, which then allowed for the supply of the medicine and they were able to continue with the purchase. The alteration was not auditable and did not flag to the prescriber or pharmacy.”

The Committee notes that UK Meds had until 27 October 2019 to correct this approach, and had not responded to this issue by 1 November 2019. The Registrant started working at UK Meds on 5 November 2019. The Committee does not have evidence of UK Meds’ practice during the time the Registrant was working there.

b. NR provided evidence that she inspected Pharmacorp on 6 April 2022. NR’s notes from the visit set out that the consultation gives a: *“Pop up to negative responses to questionnaire.”* There is no mention of another type of consultation in NR’s notes. In her oral evidence, NR expanded on this point setting out that if a patient provided a response to a question which prevented them from obtaining the medicine, this would be highlighted with a message, *“Unable to continue based on this selection please contact our support team”*. The patient could then change

their answer and proceed with the order. It was possible for responses to be changed by patients in order to obtain a prescription and supply.

- c. The Registrant's evidence that he was not aware that patients could alter their answers in the questionnaire. For repeat patients, previous questionnaires were available for comparison, which he would check for changes.
- d. The Registrant's evidence that at UK Meds, a colour coding system was introduced in early 2020 which colour coded or changed the font of answers that had been changed.

150. Given:

- a. the Committee only has evidence of the Registrant working at Pharmacorp on 6 April 2022, when its questionnaire could be manipulated by patients, as it highlighted to them answers which could prevent the supply of the medication they desired and permit the patient to change their answer;
- b. and having such a facility would allow patients to abuse the online pharmacy process, thereby leading to the prescribing model or service being incapable of supporting safe prescribing decisions;

the Committee considers it more likely than not that the Registrant prescribed in circumstances where the prescribing model or service was incapable of supporting safe prescribing decisions in that the questionnaire at 6.3 above could easily be manipulated by patients as it highlighted to them answers which could prevent the supply of the medication they desired and permit the patient to change their answer. However, this is only on a limited basis of the Registrant working at Pharmacorp on 6 April 2022.

151. Consequently, the Committee finds Allegation 6.4 found proved on a limited basis of the Registrant working at Pharmacorp on 6 April 2022.

This particular is found proved.

Allegation 7.5: In relation to 1 above, on or around 14 June 2021, you prescribed Propranolol to Patient A, a patient with a history of poor mental health and/ or self-harm in circumstances where you failed to request a face-to-face consultation with the patient in order to adequately examine the clinical need for medication

152. The Committee has considered the following evidence:
- a. UK Meds did not have facilities to have face-to-face or virtual consultations.
 - b. The Registrant has set out that he now accepts that the absence of face-to-face consultation or virtual consultation does not support safe prescribing in most circumstances, but not all.
 - c. On 10 May 2020, UK Meds prescribed 10mg of Propranolol to Patient A, 28 tablets to take on a daily basis.
 - d. On 14 June 2021, the Registrant, who was working at UK Meds and would have access to the 10 May 2020 prescription, prescribed 40mg of Propranolol to Patient A, 84 tablets to take on a daily basis.
 - e. The Registrant's evidence that having anxiety and a previous prescription for Propranolol could amount to a mental health condition.
 - f. Patient A's questionnaire which sets out the cause of her anxiety to be "*Exam stress, university lifestyle, current global climate*"
 - g. The Registrant's evidence that concerning Patient A, at the time, it did not concern him that Patient A had ticked the box that said she did not have a mental health condition; he considered that he had sufficient information that he needed to inform his decision making. In hindsight, however, the Registrant considered that at least a telephone conversation would have assisted him to provide more information. However, at UK Meds, there was only the facility to communicate through a messaging system.
153. Given that:
- a. UK Meds did not have facilities to have face-to-face or virtual consultations;

- b. The Registrant has set out that he now accepts that the absence of face-to-face consultation or virtual consultation does not support safe prescribing in most circumstances, but not all;
- c. Propranolol being a high risk medication;
- d. The Registrant did not provide a reason for the increase in dosage and duration of taking the tablets, especially given that it is expected that university exams were unlikely to go longer than the end of June; and
- e. In hindsight, the Registrant considered that at least a telephone conversation would have assisted him to provide more information;

the Committee considers it more likely than not that the Registrant prescribed Propranolol to Patient A, a patient with a history of poor mental health and/ or self-harm, in circumstances where he failed to request a face-to-face consultation with the patient in order to adequately examine the clinical need for medication.

154. Consequently, the Committee finds Allegation 7.5 found proved.

This particular is found proved.

Evidence on Grounds and Impairment

155. The Registrant provided the following oral evidence on grounds and impairment:

- a. He accepts that the admitted/proven allegations amount to misconduct. The absence of robust clinical processes contributed to what went wrong.
- b. At the time of the allegations, he was working in a repetitive pattern. There was a lack of taking adequate steps that he was reviewing his own practice. He was not taking enough “*pause moments*” to reflect on his own practice.
- c. His practice is now about continuous learning and growth.
- d. His most serious failing as a pharmacist was not working collaboratively for patient care. He should have taken a holistic approach to patient-centred care; this involves all healthcare professionals responsible for a patient. He now prides

himself on working within a multi-disciplinary team, and knowing all the care the patient is receiving, including primary care, secondary care, tertiary care and community-based services.

- e. For his remediation, reflection is only one part of it. He has also reflected and put things into practice after learning, such as having an empathy-based approach.
- f. He has observed what has happened at online pharmacies and understands that there is a need for accountability and responsibility. He was under the belief that the information that he was being given was “100% true” without questioning it. He joined the online pharmacy sector as junior in the role and seeing the senior pharmacists practice gave him a false sense of normalised practice. Having seen senior colleagues undertake this practice, he got comfortable that responsibility could be shared. He now knows that responsibility cannot be shared.
- g. The seriousness of this matter dawned on him when the first interim order was put in place. Only when pressed by Mr Wigg did the Registrant acknowledge the seriousness of the matter when contacted by the coroner.
- h. He only saw patients on part of their healthcare journey. He now understands that there were steps in between where there are unknowns in the patient’s journey.
- i. He considers now that he should be in a position to challenge SOPs if he considers them to be wrong.
- j. He is hopeful to start a PhD in pharmacy.
- k. He considers that curiosity and patient-centred care come hand-in-hand. There is a need for pride and an understanding of responsibility. He would give this advice to new professionals. Curiosity is important where there are unknowns in the patient’s journey. A pharmacist will never have full information, but one needs to look as to why there is insufficient information; curiosity is part of this. He will not challenge the appropriateness of information that is given to him.
- l. Patient’s may have hidden characteristics. Often, these are the most important to understand.

- m. He has worked, and reflected, with Dr A and Dr R. He now considers what a patient must be thinking when they see a healthcare professional. He now has an empathy-based approach, which is the first thing he considers when he sees a patient. He considers such an approach would have been important when considering what Patient A must have been feeling. He changes the way he asks questions to patients and sees if he can feel their response. This is to open conversations to understand a patient's journey.
- n. When he undertakes CPD, he also reflects on what the CPD actually means.
- o. He considers patient safety and the vulnerability of the patients. He now knows when it is appropriate to proceed with a patient consultation/investigation. He tries to be in a position to reflect if there are any patient vulnerabilities that he needs to reflect on.
- p. Although healthcare is evolving, including remote working, a pharmacist's responsibilities should not change because their working method has changed.
- q. He has four pillars upon which he relies in his life: education (which is progressive and ever changing); clinical practice (which includes pride in insight and safeguarding); professional practice; and personal life.
- r. When he was under the supervision of Dr A, he went back to basics. He realised that he was not challenging his learning and that he had to reflect and review his practice. This was a very tough 18 months working across different conditions. He cannot split his professional and personal hat.
- s. Since July 2026, when an interim suspension order was put in place, he has been a senior administrator, where he reviews and audits spreadsheets. Prior to the interim suspension order, he was a GP practice pharmacist between January and July 2026.
- t. The terms of his interim conditions of practice order changed in January 2026, due to a breach of the previous conditions which was a result of ambiguity in the conditions. There was no intention to breach the conditions. He has learned the

lesson to be more open with the regulator and to focus on regulatory compliance.

- u. His approach now to prescribing decisions is to:
 - i. look at patient safety first.
 - ii. look at the method and dialogue to gather information.
 - iii. question whether he has all the information to assist the patient.
 - iv. look at the healthcare system the patient is in, including out of hours, hospital settings, any CBT care, etc.
- v. **[PRIVATE]**
- w. Were he to work for an online pharmacy in the future, he would critique the system; see how things are happening; and determines whether it impacts upon him.
- x. He spent 12 months speaking with different professionals as to who could become his mentor. During his prescribing qualification training, he chose diabetes as his specialist area. He started off with direct supervision, then clinical supervision for six months, then shadowing other healthcare professionals such as the nursing team.
- y. His awareness of the Council's professional standards was refreshed following his prescribing qualification training, which completed in August 2018. He has always adhered to them. There was always the intention to keep patients at the centre of his practice. There were no double standards for any patients that he looked after.
- z. If he is working in different clinical settings, he adapts his practice for each clinical setting. He has always considered his practice to include challenging prescriptions.

Submissions on Grounds and Impairment

156. Having found particulars of allegation admitted/proved, the Committee went on to consider whether the allegations amounted to the grounds of misconduct and, if so, whether the Registrant's fitness to practise is currently impaired.
157. In relation to misconduct, on behalf of the Council, Mr Wigg submitted that:
- a. The Registrant has fallen below the standards ordinarily required to be followed by a practitioner in the particular circumstances.
 - b. The Registrant's conduct engaged the following Standards for Pharmacy Professionals dated May 2017 ("Standards"):
 - i. Standard 1: Pharmacy Professionals must provide person-centred care.
 - ii. Standard 2: Pharmacy professionals must work in partnership with others.
 - iii. Standard 3: Pharmacy professionals must communicate effectively.
 - iv. Standard 5: Pharmacy professionals must use their professional judgement.
 - v. Standard 6: Pharmacy professionals must behave in a professional manner
 - vi. Standard 9: Pharmacy professionals must demonstrate leadership.
158. In relation to current impairment, on behalf of the Council, Mr Wigg submitted that:
- a. The Registrant accepts that he is impaired in the wider public interest.
 - b. This is not a competence case, but a case which relates to the Registrant's misconduct concerning decisions made during his clinical practice.
 - c. The central issue is whether he has sufficiently remediated his practice. The Council does not consider that the Registrant has sufficiently remediated his practice.
 - d. It is a matter for the Committee whether the Registrant's conduct can be remediated. The Committee should note:

- i. The severity of the misconduct is problematic.
 - ii. He started working for an online pharmacy within a year of being able to prescribe. He would have been aware of the Standards and guidance at the time of his training, but he did not follow guidance when he started working at an online pharmacy. This shows that there is a risk of repetition as only a short time after his training, did the Registrant's practice regress.
 - iii. There appears to be a double standard from the Registrant where he treated some patients safely, but not others. Such double standards cannot be remediated.
 - e. Although Dr A has provided evidence that the Registrant refuses prescriptions and seeks further advice, the Registrant was already doing that at the time of the allegations. This does not take his remediation any further.
 - f. The Registrant has recently breached an interim order. This is another example of the Registrant not abiding by the Council's guidance and orders.
 - g. There is an issue of insight. The Registrant provided evidence that the seriousness of the misconduct dawned on him when the interim order was imposed. Only after prompting from the Council, the Registrant said that the seriousness of this matter only dawned on him when the coroner contacted him.
 - h. Consequently, the Registrant still poses a risk to patients and the public, and there is a risk of repetition.
159. In relation to misconduct, on behalf of the Registrant, Mr Smalley did not make any submissions. The Registrant provided evidence that the admitted/proven allegations amount to misconduct.
160. In relation to impairment, on behalf of the Registrant, Mr Smalley submitted:
- a. This is a serious case, but the seriousness is not being minimised. This is not a dishonesty case.

- b. The Registrant has taken responsibility for his actions and has not sought to blame others.
- c. However, the misconduct in this matter is not isolated to the Registrant himself.
- d. The Registrant is a bright individual. At the time of the allegations, he was a relatively new prescriber. There were limitations in remote prescribing, which was a developing area for clinical and legal practice. It is important for the Committee to take into account the type of organisations which the Registrant worked for.
- e. The concerns in this case have been addressed by the Registrant. There is ongoing reflection from 2022, evidence of professional testimonials and significant amount of other evidence. The Registrant's reflection is of significant quality. He has developed an expertise in questionnaire only pharmacy; the fragmentation of the healthcare system; a 5-point checklist; and the importance of communication between healthcare professionals.
- f. The Registrant has thought deeply about what went wrong.
- g. The Registrant has remediated his practice – over a period of four years – by:
 - i. Working in all areas of the NHS to see how the system worked;
 - ii. Working in NHS 111;
 - iii. Obtaining specialist mental health training; and
 - iv. Obtaining extensive supervision.
- h. The Registrant has developed significant and good quality insight into the dangers of working in organisations such as UK Meds. When he was working at these organisations, he was working in a bubble. The Registrant poses less of a risk than other pharmacists should he return to an online pharmacy given he has spent so much time understanding the risks.
- i. The interim suspension order applied to the Registrant in July 2026 provides no further concerns about his clinical practice. No new evidence was put forward

concerning the Registrant posing a risk to the public or poor communication with the Council.

- j. There is a low risk of repetition given the causes of misconduct have been identified; a significant amount of remediation has taken place; and there is insight present.
- k. Since the start of these proceedings, the Registrant has been subject to an interim order, including interim conditions of practice, which included strict conditions and supervision. There have been nine interim order reviews and three high court extensions. His misconduct has not gone unmarked. His prescribing has been audited. The public interest is also served by allowing a competent and qualified practitioner return to practice unrestricted.
- l. The Registrant is fundamentally a different practitioner to the one which was present at the time of the allegations. There is a benefit for other practitioners to have the Registrant's experience of these proceedings and what he has learned.
- m. Therefore, the Registrant is not currently impaired, or in the alternative, impaired only in the wider public interest.

Decision on Grounds

161. 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).

162. The Committee accepted and applied the following definition of "*misconduct*":

"...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 practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word 'professional' which links the misconduct to the profession. Secondly, the misconduct is qualified by the

word ‘serious’. It is not any professional misconduct which will qualify. The professional misconduct must be serious.”

163. The Committee also took into account the observation of J Collins in *Nandi v GMC [2004] EWHC 2317 (Admin)* that: *“The adjective ‘serious’ must be given its proper weight and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners.”*
164. The Committee considered that by committing the conduct set out in the allegations, the Registrant fell short of what would be proper in the circumstances, and would be regarded as deplorable by fellow practitioners. The Registrant conducted a vast, unsafe, online and international dispensing operation which had a very high potential to put patients and the public at a risk of harm from medicines liable to abuse and misuse without proper medical oversight.
165. Further, such actions damage public confidence in the profession, as it would convey a degree of opprobrium to the ordinary intelligent citizen (*Shaw v General Osteopathic Council [2015] EWHC 2721 (Admin)*).
166. The Committee considered whether the Registrant had breached any of the Council’s Standards. The Committee determined that there had been a breach of the following Standards as a result of the misconduct. In particular:
 - a. Standard 1: Pharmacy Professionals must provide person-centred care. In particular, the Registrant prescribed medication in circumstances where he:
 - i. failed to obtain adequate information in relation to the patients’ health (including medical records) in advance of prescribing;
 - ii. relied principally on the information received in an online questionnaire;
 - iii. failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication; and
 - iv. failed to refer patients back to their GP for appropriate assessment and/or review and/or monitoring.

- b. Standard 2: Pharmacy professionals must work in partnership with others. In particular, the Registrant prescribed medication in circumstances where he:
 - i. failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication; and
 - ii. failed to refer patients back to their GP for appropriate assessment and/or review and/or monitoring.
- c. Standard 3: Pharmacy professionals must communicate effectively. In particular, the Registrant prescribed medication in circumstances where he:
 - i. failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication; and
 - ii. failed to refer patients back to their GP for appropriate assessment and/or review and/or monitoring.
- d. Standard 5: Pharmacy professionals must use their professional judgement. In particular, the Registrant prescribed medication in circumstances where he:
 - i. failed to obtain adequate information in relation to the patients' health (including medical records) in advance of prescribing;
 - ii. relied principally on the information received in an online questionnaire; and
 - iii. failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication.
- e. Standard 6: Pharmacy professionals must behave in a professional manner. In particular, the Registrant prescribed medication in circumstances where he:
 - i. failed to obtain adequate information in relation to the patients' health (including medical records) in advance of prescribing;
 - ii. relied principally on the information received in an online questionnaire;
 - iii. failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication; and

- iv. failed to refer patients back to their GP for appropriate assessment and/or review and/ or monitoring.

167. 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 establish that the Registrant's fitness to practise is impaired (Rule 24(11)).
168. Accordingly, the Committee concluded that, in its judgement, the grounds of misconduct are established.

Decision on Impairment

169. 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.
170. At the outset, the Committee considered the Registrant's insight and remediation.
171. The Committee first considered whether the misconduct identified in this case was capable of being remedied. The Committee was of the view that although it was hard to remediate, it was possible.
172. The Committee considered that the Registrant has shown insight, although it falls short of the insight being sufficient, given:
- a. The Registrant has shown a lot of insight in relation to training, the risks of online pharmacies, and his current practice. The Committee commends the Registrant for the ongoing reflection since 2022, and his continued insight journey.
 - b. The Committee felt that the Registrant's insight to fall short where:
 - i. he provided evidence that he has always adhered to the Standards. However, he also admitted that his practice was not patient-centred (Standard 1). There appeared, to the Committee, that such a contradiction demonstrated that, although the Registrant had completed a significant amount of his insight journey, there was a little further to go.

- ii. His understanding of the seriousness of the misconduct appeared to be somewhat limited. In particular, when he provided evidence that the seriousness of this matter dawned on him when an interim order was put in place. It was only when pressed, that the Registrant said that the seriousness of the matter also dawned on him when the coroner contacted him. The seriousness of the matters appeared to only dawn on the Registrant when they personally impacted upon him, rather than the effect on others.
- 173. Similarly, the Committee considered that the Registrant has taken significant steps to remediate his practice, although the remediation falls short of being sufficient, given:
 - a. The Registrant has remediated his practice – over a period of four years – by:
 - i. Working in all areas of the NHS to see how the system worked;
 - ii. Working in NHS 111;
 - iii. Obtaining specialist mental health training; and
 - iv. Obtaining extensive supervision.
 - b. However, as of January 2026, the Registrant breached conditions of his interim order. This could have been avoided if he has adequately communicated with the Council prior to undertaking roles which may have risked a breach. The Committee considered that this demonstrated that the Registrant still has not fully remediated his practice in relation to communication and understanding guidance/orders from the Council.
- 174. The Committee considered whether the particulars found proved show that actions of the Registrant:
 - a. present an actual or potential risk to patients or to the public;
 - b. have brought, or might bring, the profession of pharmacy into disrepute;
 - c. have breached, or might breach, one of the fundamental principles of the profession of pharmacy; or

d. mean that the integrity of the Registrant can no longer be relied upon.

Whether the Registrant presents an actual or potential risk to patients or to the public

175. The Committee considered that the Registrant's conduct as set out in the admitted/proven allegations presented an actual risk of harm to patients and the public. In particular, the Registrant prescribed medication in circumstances where he:
- a. failed to obtain adequate information in relation to the patients' health (including medical records) in advance of prescribing;
 - b. relied principally on the information received in an online questionnaire;
 - c. failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication; and
 - d. failed to refer patients back to their GP for appropriate assessment and/ or review and/ or monitoring.

This presented a risk of harm to the patients and the public.

176. Given the deficiencies in insight and remediation completed by the Registrant, as set out in paragraphs 172-173 above, the Committee considered that the Registrant is liable in the future to act so as to put a patient or a member of the public at unwarranted risk of harm.

Whether the Registrant has brought, or might bring, the profession of Pharmacy into disrepute

177. The Committee considered that the Registrant's misconduct, as set out in paragraph 175 above, has brought the profession of pharmacy into disrepute.
178. Given the deficiencies in insight and remediation completed by the Registrant, as set out in paragraphs 172-173 above, the Committee considered that there is a risk that the Registrant might, in the future, bring the profession of pharmacy into disrepute.

Whether the Registrant has breached, or might breach, one of the fundamental principles of the profession of Pharmacy

179. The Committee considered that the Registrant's conduct, as set out in the allegations, has breached more than one of the fundamental principles of the profession of pharmacy, namely:
- a. Standard 1: Pharmacy Professionals must provide person-centred care.
 - b. Standard 2: Pharmacy professionals must work in partnership with others.
 - c. Standard 3: Pharmacy professionals must communicate effectively.
 - d. Standard 5: Pharmacy professionals must use their professional judgement.
 - e. Standard 6: Pharmacy professionals must behave in a professional manner.
180. Given the deficiencies in insight and remediation completed by the Registrant, as set out in paragraphs 172-173 above, the Committee considers that the Registrant might breach one of the fundamental principles of the pharmacy profession in the future.

Whether the Registrant's conduct or behaviour shows that the integrity of the Registrant can no longer be relied upon

181. Although the Registrant's integrity was raised by the Council in its skeleton, this is not an integrity case. The Committee considered that the Registrant's integrity can be relied upon.

Committee's conclusion on impairment

182. In light of the above, the Committee considered the Registrant's fitness to practise to be impaired on the personal element.
183. Further, members of the public would be appalled to learn that a pharmacist had conducted the actions set out in the admitted/proven allegations. In particular, the Committee noted that the allegations are similar at four separate online pharmacies. Consequently, the Committee considered the Registrant's fitness to practise to be impaired on the wider public interest element, namely maintaining public confidence in the pharmacy profession and upholding professional standards.

Outcome

184. 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 Pharmacy Order 2010. 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.
185. 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 in the profession and to promote professional standards. The Committee is therefore entitled to give greater weight to the public interest over the Registrant's interests.
186. The Committee had regard to the Council's *"Good decision making: Fitness to practise hearings and outcomes guidance"*, published in March 2024 ("Guidance"), to inform its decision.
187. On behalf of the Council, Mr Wigg submitted:
- a. Removal is the only appropriate outcome.
 - b. As the Registrant's proven/admitted misconduct is fundamentally incompatible with the practice of pharmacy, a suspension is not appropriate, and only removal would be an appropriate outcome.
 - c. Aggravating factors include:
 - i. The length of time the Registrant practised in online prescribing.
 - ii. The death of Patient A.
 - iii. The risk of harm to others.
 - iv. The number of prescriptions involved.
 - v. The misconduct took place over four online pharmacies.

- vi. The Registrant breached interim conditions of practice.
 - d. Mitigating factors include:
 - i. The Registrant does not have any previous fitness to practise concerns.
 - ii. The Registrant has endeavoured to remediate his practise.
188. On behalf of the Registrant, Mr Smalley submitted:
- a. The Committee should consider the imposition of conditions of practice. The conditions could include:
 - i. A named workplace supervisor.
 - ii. Reports from the workplace supervisor.
 - iii. A requirement for continued reflective work.
 - iv. That the Registrant's prescribing be audited.
 - b. Aggravating factors include:
 - i. This is a serious case.
 - ii. The length of time the Registrant practised in online prescribing.
 - iii. The risk of harm to others.
 - iv. The Registrant's failure to obtain GP records.
 - v. The misconduct took place over four online pharmacies.
 - c. Mitigating factors include:
 - i. The Registrant has shown a lot of insight in relation to training, the risks of online pharmacies, and his current practice. The Registrant has undertaken ongoing reflection since 2022. This has been commended by the Committee.
 - ii. The Registrant has remediated his practice – over a period of four years – by:
 - 1. Working in all areas of the NHS to see how the system worked;

2. Working in NHS 111;
3. Obtaining specialist mental health training; and
4. Obtaining extensive supervision.

The Registrant's remediation has been commended by the Committee.

- iii. The Registrant has continued to engage in proceedings.
 - iv. The Registrant does not have any previous fitness to practise concerns.
 - v. The Registrant does not lack integrity.
- d. The Committee has found that the Registrant is not fundamentally unsafe in his practice; there is a little more action for the Registrant to undertake to remediate and to develop insight, such as better communication with the Council. These concerns could be addressed by conditions of practice, which have worked for the vast majority of the time under which the Registrant was under an interim order.
- e. Public confidence in the profession would also be maintained where the public would benefit from an experienced practitioner. The seriousness of this matter has been marked by:
- i. The factual findings, finding of misconduct and impairment in this case;
 - ii. four years of regulatory proceedings;
 - iii. strict interim conditions and supervision;
 - iv. nine interim order reviews; and
 - v. three high court extensions.
189. The Committee noted, and took into account, the submissions of Mr Wigg and Mr Smalley.
190. The Committee considered the following to be aggravating factors in this case:
- a. Over 2 years and 7 months, and over four online pharmacies, the Registrant prescribed at least 8,243 high-risk medicines.

- b. He did so with limited information, often just a questionnaire filled in by the patient, without any corroboration or verification, thereby placing patients at risk of harm.
 - c. Patient A was vulnerable.
 - d. The Registrant breached an interim conditions of practice order.
191. The Committee considered the following to be mitigating factors in this case:
- a. The Registrant has engaged in the proceedings, and admitted to many of the allegations.
 - b. The Registrant has no previous fitness to practise concerns.
 - c. The Registrant received positive references.
 - d. The Registrant has shown insight in relation to training, the risks of online pharmacies, and his current practice. The Registrant has undertaken ongoing reflection since 2022.
 - e. The Registrant has remediated much of his practice – over a period of four years – by:
 - i. Working in all areas of the NHS to see how the system worked;
 - ii. Working in NHS 111;
 - iii. Obtaining specialist mental health training; and
 - iv. Obtaining extensive supervision.
192. The Committee considers that the Registrant’s proven/admitted misconduct makes taking no action or imposing a warning insufficient to adequately meet the wider public interest of maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour. Therefore, the Committee finds that taking no action or issuing a warning to be inappropriate.
193. The Committee next considered the imposition of conditions of registration on the Registrant. Given the seriousness of the admitted/proven misconduct, the

Committee considered that conditions would not adequately meet the wider public interest of maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour. The Committee would have given serious consideration to the imposition of conditions of practice if the Registrant was not impaired in the wider public interest.

194. The Committee next considered whether suspension would be an appropriate and proportionate outcome.
195. The Committee noted the cases of:
 - a. Akhtar v General Dental Council [2017] EWHC 1986 (Admin) which set out that whether an interim suspension order has any effect on the proper sanction to be imposed is a matter for the Committee to decide; and
 - b. Kamberova v NMC [2016] EWHC 2955 (Admin) which set out that common fairness dictates that committees must take into account any interim order and its effect on the Registrant when deciding on whether a sanction is proportionate.
196. The Committee considered that a suspension would be an appropriate and proportionate outcome, given:
 - a. The Registrant's misconduct can be remedied and he is close to remediating it.
 - b. The Registrant has demonstrated continuing developing insight, with only a few deficiencies.
 - c. The Registrant has produced positive references.
197. Nevertheless, the Committee considered that the Registrant's misconduct was extremely serious for the reasons set out at paragraph 166 above. The Registrant's misconduct placed patients at serious risk of harm, some of which crystallised. The unacceptable nature of the Registrant's practice needs to be marked in the wider public interest of maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour.

198. Consequently, the Committee considered a suspension of 6 months to be appropriate and proportionate. The Committee would have imposed a suspension of 9 months were he not given an interim suspension order in his interim order review dated 7 July 2026. The Committee noted that the interim order was changed from interim conditions to an interim suspension solely based on findings of this Committee at Stage 1 of the Principal Hearing, which took place between 13-24 April 2026. The Committee noted, in particular paragraph 43 of the interim order decision dated 7 July 2026, which sets out:

“The Committee has concluded that it is no longer appropriate for Mr Obeng to be permitted to continue in practice subject to conditions, as no conditions could be formulated which would maintain public confidence in the profession and in this regulatory process, now that the facts alleged (albeit with minor amendments), since 2022, have been found proved.”

199. For the reasons set out in paragraph 195, the Committee considered that removal from the register was a disproportionate and inappropriate outcome.

Review Hearing

200. The Committee directs that a review takes place prior to the end of the six-month suspension. Any reviewing committee would be assisted by:
- a. A written reflective piece from the Registrant setting out:
 - i. The seriousness of the admitted/proven allegations and their impact upon patients, colleagues, pharmacies, the public and the wider pharmacy profession;
 - ii. The Standards that have been breached and how they would not be breached in the future; and
 - iii. How he intends to communicate with the Council going forward.
 - b. The Registrant’s attendance at any review hearing.

Interim Order

201. The Committee directs that, pursuant to Article 56(10) of the Pharmacy Order 2010, as it has been determined that the Registrant's fitness to practise is impaired, the interim order which is currently in place be revoked.

Decision on Interim Measures

202. Mr Wigg made an application for an interim measure of suspension to be imposed on the Registrant's registration, to take effect from today's date, pursuant to Article 60 of the Pharmacy Order 2010, pending the coming into force of the Committee's substantive order. He submitted that an interim measure would be consistent with the substantive order imposed by the Committee. The Registrant's unrestricted registration would place patients and the public at risk of harm and have an impact on public confidence and upholding standards.
203. Mr Smalley did not oppose the application.
204. In considering Mr Wigg's application, the Committee took account of the fact that its decision to suspend the Registrant from the Council register will not take effect until 28 days after the Registrant is formally notified of the outcome, or until any appeal is concluded.
205. The Committee has found that there remains a risk that the Registrant might repeat his conduct, if permitted to return to work unrestricted. For the reasons set out in this decision, the Registrant's unrestricted registration would place patients at risk of harm and have an impact on public confidence and upholding standards. The Committee is satisfied that it is necessary for an interim measure to be put in place to protect the public and safeguard the public interest during the appeal period.
206. The Committee is satisfied that it is therefore appropriate for an interim measure to be in place prior to the taking effect of the substantive order.
207. The Committee hereby orders that the entry of the Registrant in the register be suspended forthwith, pending the coming into force of the substantive order.

208. This concludes the determination.