On **17 November 2026** the General Pharmaceutical Council's Investigating Committee considered an allegation in relation to **Mr Aidan Patrick Connolly, registration number: 2070186** and determined to issue the registrant concerned with a warning in relation to the conduct alleged.

The Committee concluded that the appropriate outcome in this case is a warning with the wording of:

> The Registrant is a Pharmacist and Superintendent Pharmacist of Denny Pharmacy, 1 Stirling Street, Denny, Falkirk, FK6 6EL.
>
> On 20 June 2025, an urgent request was received from a care home for medication required for a patient being discharged from care. The medication, prepared in blister pack form, included Metformin. During preparation of the blister pack, a dispenser selected and packed Metformin MR 1000mg instead of the prescribed Metformin MR 500mg, two tablets to be taken twice daily. The Registrant was the final accuracy checker in accordance with the Pharmacy's SOPs but failed to identify that the incorrect strength of Metformin had been placed in the blister pack. The medication was subsequently supplied to the Patient.
>
> The Patient became unwell on 30 June 2025 and sadly passed away on 1 July 2025. Enquiries undertaken by the Patient's family led to the dispensing error being identified. The Pharmacy investigated the matter and the Registrant accepted responsibility for failing to identify the incorrect strength during the final accuracy check.
>
> The Pharmacy and the Procurator Fiscal's Office commenced enquiries into the circumstances of the Patient's death. A post-mortem and toxicology report was obtained, which recorded the cause of death as Metformin Toxicity with Diabetic Ketoacidosis and Ischaemic and Valvular Heart Disease. The post-mortem findings indicate that the dispensing error caused or materially contributed to the Patient's death.

The Registrant's conduct represents a serious departure from the standards expected of pharmacy professionals and engages the following standards:

- **Standard 1:** Pharmacy professionals must provide person-centred care, which includes making the care of the person their first priority.
- **Standard 2:** Pharmacy professionals must work in partnership with other which includes taking action to safeguard people, particularly children and vulnerable adults.
- **Standard 5:** Pharmacy professionals must use their professional judgement so that they can deliver safe and effective care which includes making the care of the person their first concern and acting in their best interest.

This incident demonstrates a failure to uphold these standards and has had the most serious consequences for patient safety.

Registrants are required to exercise appropriate care, accuracy and professional judgement when dispensing medicines and to ensure that robust checking procedures are followed at all times.

The misconduct represents a serious breach of professional standards and a failure to maintain patient safety. The Registrant is reminded of the importance of adhering to dispensing protocols, undertaking appropriate checks, and exercising professional vigilance when supplying medicines.

The Registrant is formally warned that any similar failings in the future may call into question fitness to practise and could result in further regulatory action.

This Warning is issued to mark the seriousness of the misconduct, to promote and maintain proper professional standards, and to maintain public confidence in the pharmacy profession.

The Warning will remain on the Register for a period of 12 months.