General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

In person at Cabot Square, Canary Wharf

13 -17 July 2026

By Remote Zoom Link

16, 17, and 19 November 2026

Registrant name:	Joseph Otaa Acheampong
Registration number:	2059364
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Rachel Forster (Chair) Stephen Riley (Registrant member) Victoria Smith (Lay member)
Legal Adviser:	Graeme Henderson
Committee Secretary:	Chelsea Smith (July sittings) Mark Mallinson (16 & 17 November 2026) Adam Hern (19 November 2026)
Registrant:	Present and not represented (but supported during July hearings)
General Pharmaceutical Council:	Represented by Gareth Thomas, Case Presenter And Sarah Fearon (19 November 2026 only).
Facts proved at evidence stage:	5 & 6.2
Facts proved by admission:	1,2, 3 (3.1-3.3) 4,5, 8 (8.1-8.2), 9 (9.1-9.3), 10 (10.1-10.3) 11, 12 (12.1-12.9) 13, 14, 15 (15.1-

	15.4), 16, 17 (17.1-17.2), 18 (18.1-18.3) 19 (19.1- 19.3) 20 (20.2-20.3) 21 (21.1-21.2)
Facts not proved:	6.1, 7 and 20.1
Fitness to practise:	Impaired
Outcome:	Suspension order for 9 months with review
Interim measures:	Interim suspension Order

This decision including any finding of facts, impairment and sanction is an appealable decision under *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010*. Therefore, this decision will not take effect until 17 December 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. At all material times, were the Superintendent Pharmacist ("SI"), and/or regular Responsible Pharmacist ("RP"), and the sole Director of Jaspers Health Limited ("Jaspers"), trading as TT Pharmacy, Croydon ("TT Pharmacy") and/or Late Night Columbia Chemist, Bournemouth ("Late Night Pharmacy"). ***Admitted***

2. Were the contact name and, until 2 April 2022, the Responsible Person for the wholesale dealer's licence held by Jaspers. **Admitted**

3. Between, on or about 28 January 2022 and 1 July 2022, did not comply with the guidelines of 5 November 2013 on good distribution of medicinal products for human use namely. **Admitted**

3.1 adequately maintain the premises, equipment and/or facilities for the handling, storage and/or distribution of medicinal products; **Admitted**

3.2 maintain an adequate knowledge of good distribution practice; and/or **Admitted**

3.3 ensure that the medicines in the basement of TT Pharmacy were being stored in adequate conditions. **Admitted**

4. On or about 1 July 2022, did not ensure any records were available for Person A to review in relation to the procurement and/or supply of medicinal products. **Admitted**

5. On 1 July 2022, stated to Person A that the stock of medicines in the box of the basement of TT Pharmacy, labelled 'By Air', was intended to be shipped from TT Pharmacy to Late Night Pharmacy, or words to that effect. **Proved**

6. Your statement at paragraph 5 was dishonest and/or lacked integrity, in that:

6.1. you knew that the stock was not being sent by air from London to Bournemouth; **Not proved**

and/or

6.2. you were attempting to mislead Person A as to the destination of the stock. **Proved**

7. On or about 1 July 2022, in your capacity as the SI for TT Pharmacy, did not ensure there was a procedure in place to prevent unauthorised access to controlled drugs, in that morphine sulphate ampoules were found in an unlocked drawer. **Not proved**

8. In your capacity as the SI and/or RP for Late Night Pharmacy, did not maintain any records of the supplies of methadone in the controlled drugs record book in relation to:

8.1. Patient D, from approximately October 2022 until December 2022; **Admitted**

8.2. Patient E, from approximately August 2022 until December 2022. **Admitted**

9. On or about 13 March 2023, in your capacity as the SI and/or RP for Late Night Pharmacy, did not ensure that the controlled drugs records for oxycodone were accurate, in that:

9.1. the record of supply of Patient C's Oxycodone in the controlled drug register did not correspond with information on Patient C's patient medication record; **Admitted**

9.2. the invoices for deliveries of oxycodone from AAH into the pharmacy did not correspond with the records entered on the controlled drugs register; **Admitted**

and/or

9.3. the last record of a balance check was completed was on 19 July 2022. **Admitted**

10. Between approximately July 2022 and on or about, 16 March 2023, in your capacity as the SI and/or RP for Late Night Pharmacy, did not maintain any, or any accurate, records in the controlled drugs registers in relation to the receipt and/or supply of:

10.1. Oxycodone; **Admitted**

10.2. Morphine Sulphate tablets ("MST"); and/or **Admitted**

10.3. Methadone. **Admitted**

11. Prior to on or about, 16 March 2023, in your capacity as the SI and/or RP for Late Night Pharmacy, were unable to produce a 'near miss' and/or clinical errors log when requested by Person A. **Admitted**

12. Prior to on or about 16 March 2023, in your capacity as the SI and/or RP for Late Night Pharmacy, did not ensure that:

12.1. all prescriptions for controlled drugs in instalments were annotated to show when a supply had been made to the patient and how much was collected; **Admitted**

12.2. members of the pharmacy team had all required training for the tasks they carry out; **Admitted**

12.3. members of the pharmacy team had read and/or signed the Standard Operating Procedures; **Admitted**

12.4. the pharmacy had a procedure in place for the safe delivery of prescription only medicines to patients; **Admitted**

12.5. the pharmacy had an adequate procedure in place for keeping and maintaining records of the delivery of prescription only medicines to patients; **Admitted**

12.6. there was an adequate procedure in place to prevent unauthorised access to controlled drugs, in that methadone was stored in the back of the delivery driver's car, with no lockable box or additional security, on more than one occasion; **Admitted**

12.7. the delivery driver had received suitable training to safely deliver medicines to patients; **Admitted**

12.8. the supervised methadone consumption service was provided to at least one patient of the pharmacy who required supervision; and/or **Admitted**

12.9. the privacy of patients was protected, in that the delivery driver's sheet had the names of other patients and/or their contact details visible to other patients. **Admitted**

13. On one or more dates prior to 16 March 2023, in your capacity as the SI and/or RP for Late Night Pharmacy, did not keep complete, or accurate, records to show which pharmacist was the RP, and when. **Admitted**

14. On or about 16 March 2023, in your capacity as the SI and/or RP for Late Night Pharmacy ,did not display the RP notice. **Admitted**

15. Prior to, on or about, 16 March 2023, in your capacity as the SI and/or RP for Late Night Pharmacy, did not maintain any, or any complete, records of:

15.1. the running balances of one or more controlled drugs; **Admitted**

15.2. one or more patient-returned controlled drugs; **Admitted**

15.3. one or more expired controlled drugs; and/or **Admitted**

15.4. one or more destroyed controlled drugs. **Admitted**

16. Prior to, on or about, 16 March 2023, in your capacity as the SI and/or RP for Late Night Pharmacy, did not undertake, and/or record evidence of undertaking, the date checking of medicines. **Admitted**

17. Prior to, on or about, 16 March 2023, in your capacity as the SI and/or RP for Late Night Pharmacy, did not undertake, and/or record evidence of undertaking:

17.1. recording of fridge temperatures at the pharmacy; and/or **Admitted**

17.2. recording of MHRA alerts and/or recalls which had been actioned by the pharmacy. **Admitted**

18. On or about 16 March 2023, in your capacity as the SI and/or RP for Late Night Pharmacy, did not:

18.1. provide evidence to support your statement to Person B, to the effect that the substance misuse team were aware that the pharmacy was delivering methadone to one or more patients at their homes; **Admitted**

18.2. ensure that the premises were clean, free of clutter and organised in areas away from the patients' view; and/or **Admitted**

18.3. secure controlled drugs, in that one controlled drugs cabinet was open and/or had the keys to the cabinet left in the door. **Admitted**

19. On or about 9 May 2023, in your capacity as the SI and/or RP for Late Night Pharmacy, did not:

19.1. ensure the accuracy of the controlled drugs records, in that:

19.1.1. the balance for oxycodone stated 42 tablets, but there were no tablets in the controlled drugs cabinet; **Admitted**

19.1.2. the balance for MST 10mg tablets stated 146 tablets, but there were approximately 132 tablets in the controlled drugs cabinet; **Admitted**

19.1.3. the balance for MST 5 mg tablets stated 202 tablets, but there were approximately 128 tablets in the controlled drugs cabinet; **Admitted**

19.2. ensure that an up to date record for checking was available, in that the last dates recorded were dated 2017; and/or **Admitted**

19.3. ensure that the premises were adequately maintained, in that:

19.3.1. the pharmacy was untidy; **Admitted**

19.3.2. the conservatory was cluttered; and/or **Admitted**

19.3.3. the back yard had waste boxes piled up. **Admitted**

20. Between, on or about, 17 March 2023 to 9 May 2023, in your capacity as the SI and/or RP for Late Night Pharmacy, did not:

20.1. ensure that new staff members had been enrolled on training courses; **Not proved**

20.2. ensure that the delivery driver had been enrolled on a suitable training course; **Admitted**

and/or

20.3. ensure that the RP record was complete and accurate. **Admitted**

21. In your capacity as the SI and/or RP for Late Night Pharmacy, did not ensure the delivery services provided to patients were safe, in that:

21.1. on or about 12 and/or 13 November 2022, methadone was delivered, or attempted to be delivered, to Patient A, in the absence of a valid prescription(s) and/or despite Patient A's prescription having been stopped; **Admitted**

21.2. between approximately 1 January and 17 January 2023, one or more daily doses of methadone, prescribed for Patient B, were delivered to someone other than Patient B. **Admitted**

In light of the above, your fitness to practise is impaired by reason for your misconduct.

Documentation

Document 1- Council's hearing bundle

Document 2- Council's statement of case and skeleton argument

Document 3- Registrant's Witness Statement

Document 4- Further witness statement of Dr Christopher Ellis Jones and supporting documents

Document 5- Addendum to Council's statement of case and skeleton argument

Document 6- Council's registration records relating to TT Pharmacy, Late Night Columbia Chemist, and Jaspers Health Limited together with Companies House records relating to Jaspers Health Limited

Document 7- Registrant's Bundle

Document 8- Further witness statement from Emanuela Krasteva exhibiting photographs taken by during the inspection of TT Pharmacy on 1 July 2022

Document 9 – Council's written submissions on Outcome

Witnesses

Mr Simon Denton, GPHC Inspectorate- gave live evidence at facts stage

Ms Emanuala Krasteva, MHRA - gave live evidence at facts stage

The Registrant - gave live evidence at the facts stage

The evidence of the following witnesses, who produced witness statements in terms of Rule 24 (3), was agreed and read into the record :

Mr Christopher Ellis Jones, Head of Regulatory Governance MHRA (2 Statements)

Mr David Clark, GPHC Inspector

Ms Abigail Wilson, Lead Clinical Pharmacist, The Charity 'We are with you' (2 Statements)

Ms Faye Berdinner, National Pharmacy Technician, The Charity 'We are with you '

Mr Lloyd Furness, Project Manager, Pivotal Homes

Ms Katherine Mendonca, Support Worker, Pivotal Homes

Ms Jooman Abass, GPHC Inspector

Determination

Introduction

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

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

   Stage 2. Findings of ground(s) of impairment and impairment – the Committee determines whether, on the facts as proved, a statutory ground for impairment is

established and, if so, whether the Registrant's fitness to practise is currently impaired.

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

Application to admit further evidence

6. The Case Presenter made an application, under Rule 18(5), to admit the documents listed at 4 to 6 above. The additional witness statement and supporting documents were obtained in light of the fact that the Registrant denied he was the licence holder for Jaspers. The witness statement was only finalised on the Friday before the hearing. The Case Presenter also wished to produce evidence from the Council and Companies House regarding ownership and control of the relevant businesses and the responsibilities of a responsible pharmacist. In addition, the Case Presenter produced a short addendum to the Council's statement of case which included a short passage from caselaw which defines 'lack of integrity' among professionals.

7. The Case Presenter indicated that he did not object to the Registrant's late production.

8. The Registrant did not oppose the application.

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

10. The Committee decided to admit the further documents into evidence. The Committee considered that in these 'exceptional circumstances', where both parties were late in producing documents , it would be in the interests of justice to admit all of the documents and would not prejudice the fairness of the proceedings. Admitting the documents proposed by the Council would bring clarity to the Registrant's responsibilities at the material time.

11. At a later part of the facts stage an application was made on behalf of the Council to admit a bundle of photographs taken by Emanuela Krasteva during her inspection of TT Pharmacy on 1 July 2022. Some of those photographs were already exhibited in the bundle, others showed the subject of the photograph from different angles and other photographs were new. The Registrant did not object to these photographs being lodged but urged the Committee to take into account the fact that what was being shown was not to be regarded as new material. It was simply repetition of the old material. The Committee noted that the new photographs did not add to the allegation.

12. The Registrant had produced a bundle of documents which was mainly relevant to the Impairment stage. It commenced with the witness statement that had already been received. There was no objection to it being lodged.

13. In light of the fact that neither party objected to the lodging of further documents, the Committee considered it to be fair, relevant and in the interests of justice to admit them.

Application to amend the particulars of allegation

14. The Committee heard an application from the Case Presenter, under Rule 41, to amend particulars 2,3,4 and 6 as follows:

    1. *Particular 2 was to be completely rewritten to allege that the Registrant was the Contact Name and, until 5 April 2022 the Responsible Person for the wholesale dealer's licence held by Jaspers. It had previously been mistakenly alleged that the Registrant was the licence holder for the wholesale licence when, in fact, the holder was the body corporate (Jaspers).*

    2. *In Particulars 3 and 4 the phrase 'in your capacity as the licence holder and/or the responsible person for Jaspers' was to be deleted from both particulars.*

    3. *In Particular 6, reference to particular 6 should be changed to reference to particular 5.*

15. The Registrant did not oppose the proposed amendments.

16. The Committee accepted the advice of the Legal Adviser who referred to Rule 41. That rule permitted amendment by the Committee '*unless it was of the view that the required amendment would prejudice the fairness of the proceedings.'*

17. The Committee was of the view that the proposed amendments would not prejudice the fairness of the proceedings and it would be fair to admit the proposed amendments which would clarify the factual background particularly with regards to the Registrant's responsibilities from time to time.

Registrant's response to Particulars of allegation

18. The Registrant admitted all of the particulars with the exception of particulars 5,6,7 and 20.1.

19. In the light of the above, and by the application of Rule 31(6) of the Rules, the Chair announced that the admitted factual particulars were found proved.

20. The Committee went on to receive evidence and submissions regarding the remaining disputed particulars (5,6,7 and 20.1).

Background

21. The Respondent is a Registered Pharmacist having first registered with the Council in June 2004.
22. He is the owner and sole Director of a Limited Company, Jaspers Health Limited (Jaspers). Jaspers operates two premises which trade under two separate business names.
23. TT Pharmacy is at 174 Croydon Road, London (TT Pharmacy) and Late Night Columbia Chemist (Late Night Pharmacy) is at 21-23 Columbia Road, Bournemouth. They both operated at these addresses at the material times.
24. Jaspers has been registered with the Council as the owner of TT Pharmacy since 4 April 2017 and with Late Pharmacy since 20 February 2018.
25. The Registrant was registered with the Council as the Superintendent Pharmacist (SI) for the Company from 20 February 2015 to 13 August 2023. The Registrant admits that he was the regular Responsible Pharmacist (RP) and was also the sole director for Jaspers at the material times.
26. Particulars 2 to 7 contain allegations relating to wholesale operations at TT Pharmacy. A licence had been granted to Jaspers for wholesale dealing operations, on the premises, on 25 October 2019. The Registrant was named as the responsible person for that licence. The Medicines and Healthcare Products Regulatory Agency (MHRA) is responsible for overseeing the wholesale supply of medicines and healthcare products. A wholesale supply involves the sale of medicine and healthcare products from one business organisation to another. The Council is responsible for overseeing the operations of a registered pharmacy including the supply of medicine and healthcare products from a business to consumers.

27. The wholesale activities carried out at TT Pharmacy became the subject of inspection by Emanuala Krasteva, an Inspector with (MHRA). On 28 January 2022 she visited the premises and met the Registrant. The inspection identified a number of critical findings regarding the suitability of the premises. There was also a concern that the Registrant displayed a lack of adequate knowledge of his role as Responsible Person. Ms Krasteva issued a 'post inspection letter' dated 2 February 2022 setting out a number of deficiencies relating to the suitability of the premises and a lack of knowledge of Good Distribution Practice on the part of the Registrant. The Registrant was given 7 days to respond.

28. Although a response, dated 9 February 2022, was received it was not considered to be acceptable as it contained no firm commitments to remedy the concerns raised. The Registrant was given a further opportunity to respond and by a letter

dated 15 February 2022. MHRA received a commitment from the Registrant to address all deficiencies with a target deadline of 30 April 2022.

29. By Notice dated 1 March 2022, MHRA suspended Jaspers' Licence as a wholesale dealer (WDA). The suspension was until 31 May 2022. By Notice dated 31 May 2022 the suspension was continued until 28 February 2023.

30. By Notice dated 1 March 2022 the Registrant was informed that MHRA was minded to vary Jaspers' licence by removing the Registrant from being the 'Responsible Person'. The Registrant was invited to respond or indicate that he intended to make oral representations by 29 March 2022. No representation was made and the Registrant's name was removed from the licence as a 'Responsible Person' on 2 April 2022.

31. On 1 July 2022 Ms Krasteva visited TT Pharmacy accompanied by Simon Denton (GPHC) inspector in an unannounced follow up inspection. On 8 August 2022 MHRA issued a Notice of Proposed Revocation of the licence.

32. During the course of the 1 July 2022 inspection, Ms Krasteva had a number of concerns relating to the possibility that medicines were being wholesaled from the premises, whilst the licence was suspended. The Registrant was not at TT Pharmacy at the time of inspection and was working at Late Night Pharmacy that day. However, Ms Krasteva spoke to the Registrant briefly by phone.

33. Whilst it is alleged that on 1 July 2022, the Registrant stated to Ms Krasteva that a stock of medicines labelled 'by air' was intended to be shipped from TT Pharmacy to Late Night Pharmacy, this particular is denied. The Registrant also denied that what he said during that conversation was dishonest.

34. The inspection also revealed the presence of controlled drugs in an unlocked basement drawer. The Registrant denied that on that date he did not ensure there was a procedure in place to prevent unauthorised access to controlled drugs.

35. Particulars 8-21 relate to concerns raised in respect of Late Night Pharmacy, which did not involve MHRA.

36. On 28 November 2022 the Council received concerns from an agency which supplies housing for vulnerable adults with addiction and homelessness issues. It was said that, despite Patient A having their methadone stopped on 30 October 2022, methadone was delivered on 12/13 November 2022 by Late Night Pharmacy. (Particular 21.1)

37. Although the Registrant was contacted by telephone regarding this issue, he did not reply to an email which was sent on 15 December 2022. During a follow up phone call the Council's inspector was informed by the Registrant that one member of staff accidently sent the methadone to the home with a driver. However, the home refused to accept the delivery and it was returned to Late Night Pharmacy.

38. On 9 March 2023 Patient C complained to the Council that they had received 7 fewer tablets of oxycodone than they had been prescribed. When the matter was investigated, it was found that the drugs records for Oxycodone were not accurate (Particular 9).

39. Late Night Pharmacy was the subject of an inspection by David Clark and Jooman Abbas on 16 March 2023. The Registrant was the Superintendent Pharmacist and, on that day, the Responsible Pharmacist.

40. The Investigation revealed that Late Night Pharmacy did not maintain any records of the supplies of methadone in the controlled drugs record books in relation to Patients D and E in respect of the times set out in particular 8. There were concerns about the maintenance and accuracy of records in the registers for the receipt and supply of Oxycodone, Morphine Sulphate Tablets and Methadone. (Particular 10). There was a concern that the Registrant was unable to produce a near miss log (Particular 11).

41. Late Night Pharmacy was provided with an Action Plan to complete within 10 days.

42. On 5 May 2022, the Council received a concern from the Charity 'We are with you'. The complaint was that, between around 1 to 17 January, methadone prescribed for Patient B had been delivered to someone else. (Particular 21.2)

43. The remaining particulars relate to concerns raised by the Council regarding the operation of Late Night Pharmacy. The Registrant admitted all of these particulars with the exception of 20.1.

Decision on Facts

44. In reaching its decisions on facts, the Committee considered the documentation listed at the start of this determination, oral evidence and the submissions made by the Council and the Registrant.

45. The Committee accepted the advice of the Legal Adviser. In particular it had regard to the case of *R (Dutta) v GMC [2020] EWHC 1974 (Admin)* and the view that the starting point in the assessment of fact is to consider what was said at the time as well as contemporary records and agreed facts.

46. When considering each particular of the allegation, the Committee bore in mind that the burden of proof rests on the Council and that particulars are found proved based on the balance of probabilities. This means that particulars will be proved if the Committee is satisfied that what is alleged is more likely than not to have happened.

Particular 5:

On 1 July 2022, stated to Person A that the stock of medicines in the box of the basement of TT Pharmacy, labelled 'By Air', was intended to be shipped from TT Pharmacy to Late Night Pharmacy, or words to that effect. **Proved**

47. The Committee took into account the evidence provided by the Council and the evidence of the Registrant. It also took into account the fact that the Registrant was of good character.

48. Although this particular was disputed there was no disagreement on what was being alleged.

49. It is not in dispute that the Registrant was in Late Night Pharmacy when Ms Krasteva (Person A) and Mr Denton visited TT Pharmacy on 1 July 2022. Ms Krasteva's concern was that the part of the premises earmarked for wholesale (in the basement) contained a number of boxes containing medication. This was despite the

fact that the wholesale dealing licence had been suspended and there was no Responsible Person in place. There were large quantities of Panadol tablets indicative of wholesale distribution which had been procured following the suspension of Jaspers' licence. Weighing scales were found in the proximity of the boxes.

50. Ms Krasteva also found two carboard boxes that contained no shipping labels or other official documents which had been packed. Both boxes contained a handwritten note within them headed 'By Air 30/6/22' which listed the names of the medicines in the box.

51. One shipping box contained 120 packs of Panadol Extra, 100 packs of Augmentin suspension and 420 packs of Menthol Crystals.

52. The other shipping box contained 12 packs of Augmentin Suspension, 50 packs of Simanet plus, 100 packs of Emla cream, 10 Packs of Caverjet Dual Chamber 20mg, 7 packs of Night Nurse Capsules, 9 Packs of Day and Night Nurse Capsules and 6 packs of Day Nurse Capsules.

53. The Committee considered that on the basis of the photographic evidence, Ms Krasteva was correct to describe what she saw as a 'shipping box'. It was legitimate to draw the inference that a member of staff had made up the box on the basis of the list that was found in the box.

54. The Committee also noted that a further note of medicinal products headed 'by air' was discovered in a pile of invoices. This list of 16 products contained two different strengths of Diazepam.

55. It is not in dispute that there was a telephone conversation between the Registrant and Ms Krasteva at around 2PM on 1 July 2022. Ms Krasteva no longer has her notes regarding the inspection and her phone call with the Registrant. However, she did have those notes when she prepared her witness statement for the Council. Her witness statement is dated 6 October 2022. It was prepared around three months after the conversation. The Committee considered her to be a credible witness and

determined that it would be highly probable that she would have raised the issue that there was a concern regarding the presence of shipping boxes containing products with the instruction that they should be delivered 'by air'.

56. The Registrant did not dispute the fact that there had been a conversation between himself and Ms Krasteva. He said that he remembered Ms Krasteva referring him to boxes labelled 'by air'. Her said that he did not specifically know what was in these boxes. He said that he told her that the box mentioned in that conversation would be shipped from TT Pharmacy to Late Night Pharmacy. There was no disagreement that this exchange took place towards the end of the conversation that lasted approximately 5 minutes.

57. Accordingly, the Committee found this particular proved

6. Your statement at paragraph 5 was dishonest and/or lacked integrity, in that:

6.1. you knew that the stock was not being sent by air from London to Bournemouth; **Not Proved**

and/or

6.2. you were attempting to mislead Person A as to the destination of the stock. **Proved**

58. The Committee had particular regard to the wording of the allegation and noted that Particular 6.1 was not consistent with Particular 5. Particular 5 makes reference to labelled 'by air' whereas 6.1 makes reference to 'sent by air'.

59. The Committee had particular regard to this allegation and considered that , in light of the Registrant's good character and the requirement that cogent evidence is required to prove a charge of dishonesty brought against a professional person, it required to have careful regard to the evidence. It took into account the testimonials confirming the Registrant's good character. The Committee considered the background evidence regarding the issue of whether or not the stock in question was

destined for Bournemouth (Late Night Pharmacy) or was to be wholesaled elsewhere.

60. The Registrant stated that TT Pharmacy regularly shipped stock by air to other parts of the world. He told the Committee that what was supplied by air were vitabiotics that were not regulated by MHRA. TT Pharmacy would typically ship Vitabiotics twice a month until TT Pharmacy ran out of credit with its supplier. He also informed the Committee that, at the time of the 1 July inspection, Late Night Pharmacy had run out of credit with one supplier and that he would order medicine via TT Pharmacy to replenish stocks at Late Night Pharmacy. He also said that the basement was used as storage for excess stock related to the retail pharmacy business and was not exclusively used for the wholesale part of the business.

61. The Registrant also told the Committee that, in respect of the large quantity of Panadol purchased after Jaspers' licence was revoked, he intended, in part, to sell to friends who were other pharmacy business owners and other local pharmacies.

62. When the Registrant was asked, during his oral evidence, why there were boxes containing medicines with a list headed 'by air' he explained that he had not written the notes and did not know who had done so. However, the Registrant has produced no explanation as to why this 'error' occurred. The Committee noted that, despite the serious nature of this alleged error, the Registrant has undertaken very little investigation amongst his staff to explain why the handwritten note were written or to establish why there were boxes with medicines containing such notes in the basements.

63. The Committee also noted that his oral evidence was not corroborated by any earlier statements that he had made regarding this issue or any documentary evidence regarding the state of his business at the time.

64. The Committee reached the conclusion that as the two boxes containing medicines each contained a list of the medicines and the instruction 'by air' that they were

intended for wholesale and were intended for a destination other than Late Night Pharmacy, Bournemouth.

65. The Committee concluded that by the Registrant telling Ms Krasteva that they were to be shipped to Late Night Pharmacy the Registrant was intending to mislead her.

66. The Committee then went on to consider what the Registrant's state of mind was at the time of the phone call. He was caught unaware, as he was not present at TT Pharmacy and had been called by Ms Krasteva enquiring about products said to be shipped 'by air'. He would have been well aware that Jaspers wholesale dealing licence had been suspended and that if he admitted that the medicines were to be shipped elsewhere there would be serious consequences. In light of these circumstances the Committee found it was more likely than not that he chose to provide false information regarding the destination of the stock.

67. The Committee considered that given its findings regarding the Registrant's state of mind what he said would be considered dishonest by the standards of ordinary decent people.

68. The Committee therefore found there to be dishonesty in respect of 6.2. The Committee noted that the Registrant had been charged with a lack of integrity on an 'and/or' basis. Given that the Committee had made a finding of dishonesty it did not consider it necessary to make a separate finding of lack of integrity.

69. Although the Committee was satisfied that 6.2 of the particular was met the Committee had concerns regarding 6. 1:

6.1. you knew that the stock was not being sent by air from London to Bournemouth

70. The Committee noted that particular 5 makes no mention of the means of transport between London and Bournemouth.

71. The Committee was concerned that although Ms Krasteva alleged, in her witness statement that the Registrant said he would be flying the shipment between London and Bournemouth, there is no contemporaneous record of what was said. Whilst the Committee was satisfied that Ms Krasteva raised the issue of boxes that were marked 'by air' and that she was told that they would be heading for Bournemouth. The Registrant stated that it would be inherently implausible that he would have represented that they would be flown there and the Committee agreed that it was.

72. The Committee recognised that, in the heat of a short telephone discussion, something that may have been said by the Registrant could have been misinterpreted by Ms Krastava. Having assessed the speech patterns of two participants to the phone conversation in the witness box the Committee could not be satisfied that Ms Krasteva formed the view that she did on the basis that the Registrant truly represented that he was sending goods from London to Bournemouth by air. The Committee found it plausible that there may have been a misunderstanding regarding the conversation involving differences of perception.

73. In light of the requirement of cogent evidence being presented the Committee was not satisfied that the Council had discharged its burden in respect of Particular 6.1 .

7. On or about 1 July 2022, in your capacity as the SI for TT Pharmacy, did not ensure there was a procedure in place to prevent unauthorised access to controlled drugs, in that morphine sulphate ampoules were found in an unlocked drawer. **Not Proved**

74. It is not in dispute that, on 1 July 2022 controlled drugs were found in an unlocked drawer.

75. The Committee bore in mind the submissions of the Case Presenter who conceded that the Council may have difficulties in satisfying the evidential burden. He accepted that finding controlled drugs in an unlocked drawer may be evidence that there is no

procedure in place. However, he conceded that this could also give rise to an inference that, if a procedure was in place it had not been followed.

76. The Committee reminded itself that the Council has not investigated whether or not there was a procedure in place. In the absence of evidence of such an investigation the Council has not discharged its burden of proof. The Committee noted that Mr Denton also accepted that he had not looked for Standard Operating Procedures relating to TT Pharmacy and had not asked the Registrant to provide SOPS at that time. The Committee noted that SOPs had been provided from Late Night Pharmacy and the wholesale part of the business but it had not been provided SOPs relative to this issue. There was no evidence of a follow up investigation. The Registrant stated that there was a procedure in place and no evidence was provided contradicting this.

Particular 20.1 Between on or about 17 March 2023 to 9 May 2023 in your capacity as the SI and or RP at Late Night Pharmacy did not

20.1 ensure staff members had been enrolled on a training course **Not proved.**

77. The Committee had regard to the submissions of the case presenter. He conceded that there was limited evidence regarding this issue. An inspection revealed that some members of staff had been trained and others had not been. However, there was no evidence regarding the training of the members of staff and what training should have been undertaking.

78. The Committee accepted the Registrant's evidence that he did train his staff and that he had enrolled them on training courses once he was satisfied that they had committed themselves to his business having passed their probation period . As such the Committee was not satisfied that the Council had discharged its burden.

Misconduct

79. Having found some particulars of the allegation proved, the Committee went on to consider whether the particulars found proved amounted to misconduct. Although

Rule 31 (11) envisages that issues of misconduct and impairment should be dealt with together, the Committee was aware that 31(1) permitted the Committee to determine its own timetable.

80. The Committee considered that it would not be able to hear and determine issues of both misconduct and impairment during the remaining time that was allocated to the hearing. Whilst it could make findings of misconduct it would, in any event, be illogical to make findings of current impairment at a time when the case would be adjourned for a few months.

81. The Committee took into account the submissions made by the Case Presenter and the Registrant.

82. The Case Presenter submitted that there had been a serious falling short of the standards expected of a Registrant.

83. It was submitted that the following standards from 'Standards for Pharmacy Professionals (2017)' had been breached:

    Standard 1 – provide person-centred care

    Standard 4 – maintain, develop and use their professional knowledge and skills

    Standard 5 – use their professional judgement

    Standard 6 – behave in a professional manner

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

    Standard 9 – demonstrate leadership

84. With regard to findings relating TT Pharmacy, it was submitted that there were two categories of failings.

    · It was submitted that there had been significant breaches of duties by the Registrant who was the sole Director Jaspers, was the named contact and was the Responsible Person on the Wholesale Dealers Authorisation until he was removed in April 2022. The Case Presenter stated that it was no small thing for him to assume the responsibilities for wholesale and that there was a breach of standard 4 and, possibly standard 5.

- In respect of the findings of dishonesty the Case Presenter submitted that lying to an inspector involved a breach of standard 6 and also 5.

85. With regard to Late Night Pharmacy he submitted that there were 4 categories.
    - Procedures involving the movements of Controlled Drugs
    - Procedures regarding the activities of delivery service
    - Issues regarding the delivery of medicines including controlled drugs
    - The remaining particulars that had been found proved

86. The Case Presenter invited the Committee to have careful regard to all of the particulars found proved in order to satisfy itself that even if there had been a breach of the standards, the breach was sufficiently serious to amount to misconduct. Although there may have been a risk to patients, in respect of some of the facts found proved, there was no identified actual harm to patients.

87. The Registrant accepted the majority of the allegations and accepted that some of his actions would have amounted to misconduct in that his governance, record keeping and oversight fell below what was expected of him. He assured the Committee that there had been remediation and that he had shown insight. He also recognised the seriousness of his shortcomings regarding the finding of dishonesty. He asked the Committee to take into account the circumstances surrounding the matters in these proceedings and said that they represented a defined period in his career which had been devoted to serving the community. He had practised without incident for many years. He stressed that he did not seek to avoid responsibility for his actions and had embedded changes into the way he practiced.

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

89. There is no statutory definition of misconduct. However, in the Privy Council case of *Roylance v General Medical Council (No.2) [2000] 1 A.C. 311* Lord Clyde provided the generally accepted definition:

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

90. *There is no statutory definition of ‘lack of competence’ but caselaw has confirmed that it is a separate concept from misconduct (or professional negligence).*

91. *In Calhaem v GMC [2007] EWHC 2606 (Admin) explained the analogous concept of ‘deficient professional performance’:*

20"(3)… It connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the doctor's work.
(4) A single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute "deficient professional performance".
(5) It is neither necessary nor appropriate to extend the interpretation of "deficient professional performance" in order to encompass matters which constitute "misconduct".

92. The Committee was asked to bear in mind that the Standards may be taken into account when considering the issues of grounds and impairment but that a breach of the Standards does not automatically result in a finding of misconduct (Rule 24(11) of the Rules). There had to be a serious falling short.

93. Under reference to Schodlock v GMC [2015] EWCA Civ 769 it would not be appropriate to make findings of misconduct where there had been departures from the rules that were not sufficiently serious to constitute misconduct by accumulating these findings.

Decision on misconduct

94. When considering whether the particulars found proved amounted to misconduct the Committee took into account the *Good Decision making guidance* / Fitness to Practice hearings and Outcomes Guidance 2024 (The Guidance).

95. The Committee considered whether the Registrant had breached any of the Council's Standards for Pharmacy Professionals (May 2017). The Committee determined that there had been breaches of the following Standards:

    Standard 1 – provide person-centred care

    Standard 4 – maintain, develop and use their professional knowledge and skills

    Standard 5 – use their professional judgement

    Standard 6 – behave in a professional manner

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

    Standard 9 – demonstrate leadership

96. The Committee noted that Particulars 1 and 2 were simply narrative charges.

97. The Committee considered Particular 3 and was satisfied that there had been a contravention of Standard 4. The Registrant had assumed responsibility for the conduct of a wholesale business. The Registrant informed the Committee that he assumed that at that time he had assumed, as an experienced pharmacist, he would have the expertise to conduct such a business. The Committee considered that the matters found proved in respect of the wholesale business was too serious to be categorised as lack of competence. Furthermore the committee noted that the Registrant had taken no steps to improve his performance, take any training, recruit another Responsible Person or surrender the licence on discovering that he lacked the necessary skills and knowledge. Instead, his licence was curtailed by the Regulator taking enforcement action. It therefore found misconduct.

98. In respect of Particular 4, the Committee considered, as the inspection on 1 July 2022 was unannounced, the Committee was not provided with material to suggest that the Registrant was under a duty to ensure that records were available for

Person A. There was evidence that, in any event, Person A obtained access to some records. The Committee did not consider this to be misconduct.

99. Particulars 5 and 6 relate to the telephone conversation with Person A where he falsely represented that stock labelled 'by air' was intended for his outlet in Bournemouth. The Committee considered that its finding of dishonesty was sufficiently serious to amount to misconduct.

100. Particulars, 8, 9 and 10 all involved issues concerning poor record keeping with regard to the procurement and supply of controlled drugs. The Committee had regard to each and all of the sub particulars and considered that Standard 4 had been breached. The Committee considered that each of these breaches were sufficiently serious to amount to misconduct. With regard to Particular 8, there was a risk to patient care as there was no means of knowing what quantities of methadone each of the patients had been supplied with. The same issue applied to Patient C in respect of Particular 9.1. The Committee also considered that the lack of record keeping in Particulars 9.2, 9.3 and the whole of Particular 10 carried the risk that controlled drugs could be diverted.

101. The Committee considered that failure to produce a 'near miss' / clinical errors log, on one day, when requested (Particular 11) was poor practice but not sufficiently serious to amount to misconduct.

102. The Committee had regard to charge 12 and considered that each of the sub particulars involved conduct that was sufficiently serious to amount to misconduct with the exception of two sub particulars. The Committee considered that the wording of Particular 12.2 was vague. The fact that the Registrant admitted that he did not ensure that members of the pharmacy team had 'all' required training did not of itself identify risks to the public. In the absence of any details of what training was envisaged, the Committee was not able to find misconduct. Particular 12.3 may have disclosed poor practice but that was not sufficiently serious to amount to misconduct.

103. The Committee considered that the remainder of the sub particulars in Particular 12, with the exception of 12.9, were all individually serious failings that presented material risks to patient or public safety. Particular 12.9 created a risk that patients could be identified by unscrupulous people who happened to walk past the delivery vehicle.

104. The Committee had regard to Particulars 13 and 14. The Committee considered that the failure to keep accurate records of who the RP was over a period of time was sufficiently serious to amount to misconduct. In the event of any matter arising from the supply of a particular pharmacy services on a particular date there was no means of knowing who was on duty when that drug was dispensed. However, the Committee considered that Particular 14 involved a human error at a single point in time which involved poor practice and was not sufficiently serious to amount to misconduct. The fact that the Registrant had omitted to display a notice on one day did not meet the threshold of seriousness to amount to misconduct.

105. The Committee had regard to each and all of the sub particulars in particular 15 and considered that they all, individually, amounted to misconduct. This was another charge involving a failure to keep required records in relation to controlled drugs. Failure to do this in an accurate way presented a risk to patients and was serious.

106. The Committee noted that, in his evidence, the Registrant informed the Committee that his practice was to date check medicines when they were being dispensed. Date checking medication when it was being dispensed was only one safety measure. However, the Committee considered that a failure to undertake and record routine date checking of medicines involved the by-passing of a procedure that reduced material risks to patients. As such the Committee considered that this was sufficiently serious to amount to misconduct.

107. The Committee considered that both sub charges in Particular 17 amounted to misconduct. In respect of 17.1, a failure to record fridge temperatures meant that

there was no means of knowing whether insulin or vaccines stored in the fridge had become denatured as a result of temperature fluctuations. This inevitably would compromise patient and public safety. There were issues of potential patient and public safety risks. In respect of sub particular 17.2, there was no means of ascertaining whether the Pharmacy was aware of any MHRA alerts and whether any such alerts had been actioned.

108. The Committee considered each parts of Particular 18 separately. 18.1 is a complaint that the Registrant did not provide evidence (presumably written) to the effect that the substance misuse team were aware that the Pharmacy was making home deliveries of methadone to patients. It is not alleged that what was said was false. All that was said is that the Registrant did not produce evidence confirming that they were aware. The Committee did not consider this to be a departure from the Standards let alone misconduct.

109. The Committee then considered 18.2. This involved a complaint that the premises were unclean and cluttered. The Committee noted that the Case Presenter conceded that, whilst it was open for the Committee to form a different view, these factors may not amount to misconduct. The fact that the premises were in a particular state on a particular day was not, in the view of the Committee, a breach of the Standards for Pharmacy Professionals let alone misconduct. This was more a matter in relation to standards for Registered Pharmacies.

110. Particular 18.3 is based on the fact that, when the Pharmacy was visited ,one controlled drugs cabinet was open/ and or there was a key in the door. The Registrant was in the Pharmacy at the material time, and stated that the controlled drug cupboard was under his supervision, there was no evidence of a risk that the controlled drugs would be stolen. The Committee was unable to make a finding of misconduct.

111. The Committee considered that Particular 19.1 in its entirety disclosed further findings regarding the accuracy of three sets of controlled drug records. Particular

19.2 followed this up by noting that the last date that records were checked was around 6 years earlier. The Committee considered these matters to be sufficiently serious to amount to misconduct.

112. The Committee considered that the allegations of untidiness and cluttering did not amount to misconduct on the same basis that it did for Particular 18.2.

113. The Committee then had regard to Particular 20.2 and did not consider that the charge, as worded, could amount to a finding of misconduct. The allegation was that the Registrant should have 'enrolled' his driver for a 'suitable training course'. There was evidence, from the Registrant, that his driver was experienced in delivering wholesale drugs. Enrolling a driver on a particular course does not necessarily mean that they will complete a course. There was no requirement for the driver to complete the course.

114. The Committee considered that a failure to make complete and accurate record RP's, as set out in Particular 20.3 was sufficiently serious to amount to misconduct. They did so for the same reason as set out in their assessment of Particular 13.

115. The Committee considered that the failings set out in Particulars 21.1 and 21.2 both amounted to misconduct. Methadone was delivered in respect of a patient who had previously died and another patient whose prescription had been cancelled. There was a material risk to the public in the event that the medication could be diverted and ended up in the wrong hands.

116. Accordingly, the Committee concluded that, in its judgement, the ground of misconduct is established.

117. Having found misconduct the Committee therefore would have to go on to consider whether the Registrant's fitness to practise is impaired.

Resumed Hearing

Documents

118. When the hearing resumed on Monday 16 November 2026 the Registrant provided the Committee with the following additional documents. Most of these were sent in the early morning of the first day of the resumed hearing:

- Methadone Audit dated 13 November 2026
- Reflective account on a probity and ethics course (the Course was completed on 10 October 2026)
- 'PEIP and Reflective CPD'
- 'Reflective CPD Portfolio'
- CDP Certificate (How to ensure a similar mistake or misconduct will not be repeated in the future) 9 November 2026
- CPD Certificate (Effective Change) 10 October 2026
- CPD Certificate (Probity and Ethics) 10 October 2026
- CPD Certificate (Substance Use and Misuse) 15 May 2024
- CPD Certificate (Problem Solving) 14 June 2023
- CPD Certificate (Leadership for Healthy Living Pharmacies) 3 August 2022
- A folder containing 'All files including SOPS, RP Logs, CD Audits and balances'
- Reflective Statement Following July 2026 GPHC Determination
- A number of references

Application to adjourn

119. During the course of the Registrant's evidence, he was asked by the Committee why the documents that he had submitted, prior to the resumed part of the hearing, contained little reference to Late Night Columbia Chemist. He informed the Committee that he was under the impression that such documents had been sent. After being shown the emails which were sent by him to the Case Presenter there was no record that a significant number of documents relating to Late Night Columbia Chemist had been sent.

120. The Registrant applied to adjourn the hearing in order to produce documents.

121. The Case Presenter did not oppose this application and indicated that this was an important stage of the hearing and submitted that, since the Registrant was a litigant in person ,matters of fairness may mean that the Committee should give serious consideration to this application.

122. The Committee heard and accepted the advice of the Legal Adviser.

123. Having retired to consider this issue, the Committee considered that it was in the interests of justice to grant the Registrant's application to adjourn. Most of the misconduct related to issues concerning the Registrant's practice at Late Night Columbia Chemist. In considering current impairment, evidence relating to that pharmacy may be of greater relevance in deciding this issue. Although an adjournment would delay the progress of these proceedings the Committee was of the view that the case should still be able to conclude within the time allocated.

124. The Registrant was informed that he had until 9am the following day to produce further documents. The Committee also determined that it was unfair to leave the Registrant on his oath overnight as there may be practical difficulties in obtaining assistance with the preparation of the documentation if he were not allowed to discuss the case. He was therefore released from his oath.

125. On the following day the following documents were lodged:

- Further Registrant's bundle
- Fridge temperatures for August to October 2026

Council's Submissions

126. The Case Presenter made submissions on impairment at the start of the resumed hearing. It was intended that he would make further submissions after the Registrant had given evidence.

127. The Case Presenter reminded the Committee that there was no burden of proof and, in considering the issue of impairment, the Committee should exercise its professional judgement.

128. Under reference to the Committee's determination on misconduct he submitted that the charges that resulted in a finding of misconduct could be grouped into several categories. There were issues concerning: wholesaling; dishonesty; numerous issues with record keeping and the delivery and the checking of methadone. These were wide ranging concerns.

129. In relation to dishonesty the Committee should give careful consideration to how this came about and the full factual context. On one view this was a single instance of dishonesty.

130. The Committee was invited to consider all of the material before it and form a view on future risk as well as the other issues such as remediation and insight. The Committee was invited to have regard to all of the reflective pieces which were submitted as well as the references. Although one referee described himself as a 'mentor' no documents were produced demonstrating formal mentoring.

Councils closing submissions

131. The Case Presenter began by presenting information relating to the status of all of the Registrant's pharmacies. He informed the Committee that the pharmacies that had been inspected had met the standards.

132. He invited the Committee to make findings that the Registrant's fitness to practise was impaired. Particular emphasis was placed on the public interest element of Rule 5(2). However, it was open for the Committee to consider whether limb (a) was engaged with regard to public protection and (d) with regard to integrity.

Registrant's evidence

133. In seeking to persuade the Committee that his fitness to practise was not impaired the Registrant provided a number of documents which were submitted on the morning of the first day and later.

134. In his live evidence the Registrant made it clear that he felt regret, shame and remorse for his misconduct. He informed the Committee that his dishonesty arose as a result of being confronted by a younger female inspector who knew far more than him about wholesale operations and that he had felt embarrassed at his lack of knowledge. He told the Committee that this was the trigger for him to give inaccurate information and say something that had not been verified as opposed to saying that he did not know.

135. He was cross examined by the Case Presenter in relation to a number of documents that had been submitted for this hearing. He accepted that the fridge temperature record was incomplete. The regular responsible pharmacist did not work on Saturdays and the locum responsible pharmacist may have not measured the fridge temperature. In any event it had not been recorded. The Registrant also accepted that the Responsible Pharmacist record produced by him was incomplete.

136. During Committee questioning the Registrant accepted that a later set of documents relating to fridge temperatures submitted by him was inaccurate. It provided the wrong starting day for 1 October 2026 and had been completed erroneously by staff. He said this needed to be followed up.

Registrant's submissions

137. The Registrant submitted that he was not impaired and that he had learned from his involvement in the regulatory process. He invited the Committee to have regard to his numerous references and his attendance at appropriate CPD Courses. He explained that he had engaged a peer mentor whom he met every month and discussed matter relating to his pharmacies and regulatory matters. Although his

mentor did not keep records of their discussions he had helped him put in better procedures to address the regulatory concerns and improve the way he operated the pharmacies. The mentor had helped to put together the Registrant's personal development plan which would be rearranged regularly to reflect the discussions between them.

138. The Registrant informed the Committee that, as a result of the issues regarding Late Night Columbia Chemist he had arranged for the operating procedures to be changed and there was team work between him and other staff members, particularly his area manager, to see that matters were run correctly. Particular attention had been focussed on record keeping and management of controlled drugs.

139. The Committee was told that medicines would be regularly monitored to ensure that they were in date. If medicines were about to expire they would be labelled in order to see that they were used prior to their expiry.

140. He reiterated that, although he was not allowed to wholesale drugs, this did not prevent him from wholesaling Vitabiotics.

Legal Advice

141. The Committee heard and accepted the advice of the Legal Adviser. He referred to Rule 5(2) of the Rules, *Cohen v GMC [2008] EWHC 581 (Admin)* and Towuaghantse v GMC [2021] EWHC 681 (Admin).

Decision on Impairment

142. The Committee was aware that 'impairment' of 'fitness to practise' is defined in the Rules.

Rule 5(1) of the Rules, states that

'*The Committee must have regard to the criteria specified in paragraph (2) when deciding if the requirements as to fitness to practise are met in relation to a registrant.'*

Rule 5(2) provides:

"(2) In relation to evidence about the conduct or behaviour of the registrant which might cast doubt on whether the requirements as to fitness to practise are met in relation to the registrant, the Committee must have regard to whether or not that conduct or behaviour –

(a) presents an actual or potential risk to patients or to the public;
(b) has brought, or might bring, the profession of pharmacy into disrepute;
(c) has breached one of the fundamental principles of the profession of pharmacy; or
(d) shows that the integrity of the Registrant can no longer be relied on."

143. The Committee considered that the Registrant displayed genuine remorse when giving evidence. This was also displayed in his reflective accounts. The Committee also took into account the number of references provided regarding his practice and the noted that he has attended several CPD courses tailored to address the issues raised in these proceedings and had reflected on his learning from those courses. The Committee found this to be a positive step towards remediation.

144. However, the Committee was concerned about the level of insight which the Registrant had displayed. The Registrant was advantaged by having had a period of four months between the Committee making its findings of misconduct and the impairment stage of the hearing. It was open for him to read the determination and make careful preparation for the next stage. Rather than provide coherent and organised documentation, well in advance of the hearing, he provided documents on

the day of the hearing and later only some of which was relevant to the issues in hand. Many of the charges that resulted in findings of misconduct arose as a result of what appeared to have been chaotic organisation. There was no compelling evidence to suggest that his organisational skills had improved.

145. The Committee considered each of the limbs set out in Rule 5(2) *'(a) presents an actual or potential risk to patients or to the public;'*

146. The Committee considered that, on the evidence before it, past mistakes were likely to be repeated. The misconduct raises issues about patient and public safety. The Registrant produced evidence which demonstrated that Responsible Pharmacist records were still not complete (Particular 13) and that fridge temperatures were still not recorded (Particular 17.1) . Further, it appeared that the Registrant was not fully aware of the overall details regarding the management of his pharmacies and, despite telling the Committee at the previous hearing that he had been under significant pressure having taken on too much, it appeared that he had increased the number of pharmacies in his business and was still under similar pressure in terms of overall running of the business. It was not clear to the panel if the changes made were as a result of changes brought about by the area manager or if the Registrant himself was responsible. However, it was clear to the Committee that the Registrant did not have a clear grasp of why mistakes in the documents put before the panel had been made. The Committee was not satisfied that the Registrant fully understood what he required to do in order to protect patients and the general public. Accordingly, the Committee considered this limb to be engaged.

(b) has brought, or might bring, the profession of pharmacy into disrepute;

147. The Committee considered that the Registrant's misconduct has brought the profession into disrepute and there remains a risk of repetition. The concerns were wide ranging covering record keeping, management of controlled drugs, governance as well as dishonesty and covered a period of around 18 months. Accordingly, limb (b) was engaged.

(*c) has breached one of the fundamental principles of the profession of pharmacy;*

148. One of the fundamental principles of pharmacy is the safe and effective supply of medicines, in particular the management of controlled drugs. There were multiple breaches of that principle. Another fundamental principle relates to honesty which had also been breached. Accordingly, limb (c) was engaged.

(d) shows that the integrity of the Registrant can no longer be relied on.

149. The Committee gave careful consideration to this issue.

150. The Committee noted that there was only one allegation of dishonesty. The dishonesty was spontaneous and one off in relation to the Registrant being asked questions during an inspection by the MHRA. However, this dishonesty was aggravated by the fact that it was said in a professional capacity to an MHRA Inspector. It was also aggravated by the fact that the Registrant maintained his position, when giving evidence, that the 'by air' label was put there as a mistake. Following closing submissions on impairment the Registrant repeated his position that he was exporting items that could not be categorised as drugs.

151. The Committee was concerned that the Registrant did not fully understand the Committee's findings on this issue or else was in denial about the precise finding that had been made. Although he repeatedly told the Committee that he accepted its findings this was qualified by him describing the events, surrounding the dishonesty finding, as being as a result of his failure to verify. The Committee considered that the Registrant had displayed no level of insight and appeared to be in denial of the Committee's earlier findings . The Committee had reached the conclusion that as the two boxes containing medicines each contained a list of the medicines them and the instruction 'by air', it was clear that they were intended for wholesale and for a destination other than Late Night Pharmacy, Bournemouth. The Committee

determined that the Registrant knew this but also knew that he did not have a licence to wholesale such medicines and export them and therefore knew that the consequences of admitting this to the inspector would be serious.

152. The Committee had serious concerns about the level of integrity displayed by the Registrant and considered that this limb was engaged.

153. The Committee considered that the conduct is capable of being addressed as the dishonesty related to a single incident which may not signal a deep-seated attitudinal concern. The other matters related to professional conduct that was capable of being remediated. There was evidence before the Committee to show that the Registrant had taken some steps to address the concerns relating to professional conduct. However, as the Registrant himself admits, putting right dishonesty and remediating fundamental issues in his practice requires more than attending courses and supplying written reflection. It needs to be embedded in his practice, verified through independent observers and evidenced through changed practice. The Committee decided that more work was required to satisfy it that all of the concerns had been addressed in order to reduce the likelihood that the conduct would be repeated.

154. Accordingly, the Committee found that the Registrant's fitness to practise was impaired on the basis of both public protection and public interest.

Submissions on Outcome

155. Having found impairment, the Committee considered the matter of outcome. The Committee's powers are set out in Article 54(2) of the Order. The Committee had to consider the available outcomes in ascending order from least restrictive (take no action) to the most severe (Removal from the Register) to identify the appropriate and proportionate outcome that met the circumstances of the case.

156. The purpose of outcome was 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 the Council as regulator, namely the protection of the public, the maintenance of public confidence and to promote professional standards. The Committee was required to attach greater weight to public protection and the public interest over the Registrant's own interests.

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

158. The Committee was particularly mindful of the Outcomes Guidance at section 5 which includes the key factors to consider; the public interest, insight, testimonials, and dishonesty findings.

159. The Committee took into account the submissions made by both parties.

160. The Committee was assisted by Miss Fearon's written submissions, on behalf of the Council, on the issue of Outcome as well as her oral representations. It was submitted that, in light of the Committee's findings, the appropriate sanction be revised downwards from a suspension for a period of 12 months, proposed in the original skeleton argument, to a suspension order for a period of 6 months with review. She provided the panel with detailed submissions on what was considered, by the Council, to be the aggravating and mitigating features in this case. She also made submissions of what this Committee may recommend should be produced to a reviewing panel.

161. The Registrant began by accepting that his dishonesty did involve the panel finding that he had lied to the inspector and that this untruthful account had not been believed by the Committee. He accepted that it was wrong to categorise what he had said as an inaccuracy. He accepted that the Committee needed to see consistent evidence of progress in putting right the failings found proved especially under pressure. He submitted that the appropriate outcome should be a suspension order with review but made no submissions regarding its length.

162. The Committee heard and accepted the advice of the Legal Adviser.

Determination on Outcome

163. The Committee began by considering the aggravating and mitigating factors.

164. The Committee determined that the following factors were aggravating:

Seniority and responsibility. The Registrant was Superintendent Pharmacist, regular Responsible Pharmacist and sole director. He was responsible for the governance of both pharmacies.

Controlled drugs. The record-keeping failures were repeated, spanned many months and several drugs, and carried a risk of diversion

Vulnerable patients. Several failings concerned methadone supplied to patients receiving substance misuse treatment, including residents of supported housing for vulnerable adults.

Breadth and duration. The misconduct extended across two premises and approximately 18 months.

Dishonesty to his regulator. The false statement was made to an MHRA Inspector in the course of an inspection, when the Registrant knew the wholesale licence was suspended and that the truth would have serious consequences. The statement was made to deflect scrutiny of possible wrongdoing . He continued to misrepresent the position in his evidence to the Committee.

Wholesale Dealer License failings. Having taken on the Responsible Person role without the necessary knowledge, the Registrant took no steps to seek necessary training , recruit a suitably qualified replacement or surrender the license. The position was resolved only by MHRA enforcement action

Continuing governance deficiencies. The documents produced for this resumed hearing demonstrated that some of the same record-keeping and governance failings persist.

Limited insight into the dishonesty, as found by the Committee at the impairment stage

165. The Committee found the following features to be mitigating:

- The Registrant has been registered since June 2004, with no previous regulatory findings
- He admitted the large majority of the particulars at the outset
- He has engaged with these proceedings throughout and has represented himself;
- He demonstrated genuine remorse
- He has undertaken CPD directed at the issues in this case, including probity and ethics, substance use and misuse, and effective change, and has provided reflective accounts and a number of references
- No actual patient harm has been identified, although the Committee found material risk

Outcome

166. The Committee then considered the available outcomes in ascending order.

167. The Committee considered that the Registrant's misconduct was so serious that taking no action would not maintain public confidence in the profession or protect the public.

168. The Committee then considered whether to issue a Warning. The Committee concluded that a Warning was insufficient to address the seriousness of his behaviour, uphold professional standards or protect the public.

169. The Committee next considered the imposition of Conditions on the Registrant's practice. A Conditions Order would allow the Registrant to practise albeit with restrictions. The Committee had to determine whether a Conditions Order would be appropriate given that some of the concerns which had been identified regarding the Registrant's practice could be remedied through conditions. It had to consider in particular whether Conditions would be sufficient to mark the seriousness of the conduct so as to maintain public confidence in the profession and the Council as a regulator. It was of the view that the wide-ranging concerns involving his clinical and professional practice were too serious. Taken with the findings of dishonesty the Committee determined that imposing conditions was neither appropriate nor proportionate.

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

"*The Committee considers that a warning or conditions is not sufficient to deal with any risk to patient safety or protect the public or would undermine public confidence.*

When it is necessary to highlight to the profession and the public that the conduct of the professional is unacceptable and unbefitting a member of the pharmacy profession. Also when public confidence in the profession demands no lesser sanction."

171. The Committee considered that this case fell within the guidance given. The misconduct was serious and as such the outcome should reflect this. The Committee had found impairment on public protection and public interest grounds and the seriousness of his misconduct needed to be properly marked. The Committee concluded that a period of suspension would protect the public and uphold standards to maintain public confidence and that this was the minimum outcome necessary to send a message that such behaviour from a pharmacy professional will not be tolerated. The Committee considered that a period of suspension would also provide the Registrant with a period of time to reflect on his misconduct and take the steps necessary to address the failings identified.

172. The Committee concluded that a Suspension Order is the appropriate and proportionate outcome in this case.

173. The Committee considered carefully the appropriate period of the Suspension Order in light of the findings it had made. The Committee took into account the mitigating factors and the fact that the Registrant had had a previously long unblemished career. He has yet to address his misconduct. The purpose of the Suspension Order is to mark the seriousness of this misconduct, uphold standards of conduct expected of pharmacy professionals and maintain public confidence in the pharmacy profession. The Committee considered that, although 4 months had elapsed since its findings of misconduct, in which the Registrant could have improved his practice, he had been unable to demonstrate much improvement at the time of the reconvened hearing. It therefore considered a period of 9 months with a review would mark the seriousness of his misconduct and give him time to fully remediate.

174. The Committee did consider removal but accepted the Council's submissions that removal, at this stage, would be disproportionate.

175. The Committee considered that a future reviewing Committee would be assisted by the following:

- His continued engagement with his regulator and attendance at the review hearing

- A reflective statement showing that the Registrant understands the Committee's finding of dishonesty and the implications of other aspects of his misconduct for patients, the regulator and the profession;

- Evidence of complete and accurate Responsible Pharmacist records, controlled drugs registers, running balance checks, fridge temperature records and date-checking records at the pharmacies for which the Registrant is in charge of, verified by someone independent ;

- Evidence of the governance arrangements in place for his pharmacies during the suspension period and his plans for after the suspension;

- Evidence of that he has entered into a formal mentoring arrangement with a registered pharmacist: records of the discussions and reports prepared every 2 months by his mentor of the discussions that took place and their outcomes; reflective statements by the Registrant completed every 2 months to show his learning and his application of what has been discussed in the mentoring meetings.

- Evidence of further relevant CPD; and

- up-to-date references from people who have read the Committee's determination,

Interim measures

176. The Council made an application for an interim measure of suspension to be imposed on the Registrant's registration, to take effect from today's date, pending the coming into force of the Committee's substantive order.

177. It was submitted that an interim measure would be consistent with the substantive order imposed . 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.

178. The Registrant did not oppose the application.

179. The Committee heard and accepted the advice of the Legal Adviser.

180. In considering the 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.

181. The Committee 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 was satisfied that it is necessary for an interim measure of suspension to be put in place as it was necessary to protect the public and safeguard the public interest during the appeal period.

182. The Committee was satisfied that it is therefore appropriate for an interim measure of Suspension to be imposed to cover the 28-day period and cover any appeal.

183. That concludes this determination.