STATUTORY COMMITTEE OF THE PHARMACEUTICAL SOCIETY OF NORTHERN IRELAND

In the matter of:	Mr Martin James White (3062R)
Location:	Pharmaceutical Society of Northern Ireland's Offices, 73 University Street, Belfast, BT7 1HL
Date:	18 May 2018
Committee:	Mr Conor Heaney (Chair), Mr Jonathan Patton (Lay), Ms Catherine Glover (Registrant)
Persons Present and Capacity:	Mr JonPaul Shields, Barrister and Ms Anna McClimonds, Solicitor (PSNI's Legal Representatives), the Registrar of the PSNI
Observers:	None

Order:

1. The Committee met to review a substantive order of suspension imposed on the registration of the Registrant, Martin James White, a registered pharmacist. The Pharmaceutical Society of Northern Ireland ('the Society') was represented by JonPaul Shields. Mr White was not present nor was he represented.

2. The Committee had a hearing bundle numbering pages 1-381.

3. The suspension order was for seven months' duration and was imposed previously by the Statutory Committee after a hearing on 25, 26 and 28 September 2018. Mr White did not attend that hearing, nor was he represented. The order took effect, after the applicable appeal period, on 28 October 2017. The review was conducted before the suspension order was due to expire.

SERVICE

4. The notice of hearing, dated 13 April 2018, was sent by registered post to Mr White's registered address on the same date. A Registrant is required by the Society to receive no less than 35 days' notice of the hearing under regulation 18 of The Council of the Pharmaceutical Society of Northern Ireland (Fitness to Practise and Disqualification) Regulations (NI) 2012 ('the Regulations'). The Committee was satisfied that service of the notice of hearing had been effected on Mr White in accordance with the regulation 18.

PROCEEDING IN ABSENCE

5. The Committee considered whether it was reasonable and appropriate to proceed in Mr White's absence.

6. The Committee heard a submission from Mr Shields that the review should be conducted in Mr White's absence.

7. The Committee noted a letter sent to Mr White from the Society's solicitors dated 17 April 2018. This letter sought to engage with Mr White. He was asked to confirm whether he wished to attend the review hearing or be represented. He was also asked to provide written material in advance of the review. In an email in response, dated 26 April 2018, Mr White stated that he did not want to return to the pharmacy profession. He further stated that, *'I will not be attending the meeting on 18 May. Please advise the relevant parties.'*

8. The Committee determined that Mr White had, in his communication with the Society, voluntarily waived his right to attend the hearing. The Committee also considered that, given the serious nature of the allegations proved against him, there was a strong public interest in proceeding with the review in Mr White's absence.

BACKGROUND

9. Mr White is a registered pharmacist. He qualified in June 1996.

10. The Committee took note of the background leading to the regulatory proceedings against Mr White.

11. He had been employed, since 1 October 2005, as the Pharmacy Manager of Clear Pharmacy, based at Antrim Health Centre, until his resignation from that position in January 2016.

12. On 6 February 2014, Patient A's husband attended Clear Pharmacy with a prescription for his wife. The Patient Medication Record noted that 40 Prednisolone 5mg tablets were dispensed along with two other types of prescription medication.

13. The label on what should have been a box of Prednisolone medication (a steroid) directed 8 x 40mg tablets to be taken daily for five days. That label was mistakenly attached to a box of Propranolol (a beta blocker) 40mg tablets and dispensed to Patient A's husband.

14. Later that day, Patient A, who was aged 67, took what she believed to be the prescribed medication and quickly fell ill. She was taken by ambulance to Antrim Area Hospital where she died a short time later.

15. The investigation into the cause of Patient A's death led to the identification of a dispensing error as the precipitating factor. She had taken 8 x 40mg tablets of Propranolol and had died as a result of the toxic effects of taking them.

16. Mr White was the responsible pharmacist on 6 February 2014. He had dispensed the medication to Patient A's husband. Mr White admitted that he had filled the prescription and that he must have mistakenly picked up the Propranolol instead of the prescribed drug. He stated that the two drugs were side by side on a shelf in the dispensary of the pharmacy and that he had carried out those checks in respect of the safe dispensing of medication in

accordance with the Standard Operating Procedures then in force as issued by Clear Pharmacy.

17. After the death of Patient A, Mr White continued in his employment (with some periods of absence through ill health) with Clear Pharmacy until January 2016, when he resigned.

18. On 25 October 2016, at Antrim Crown Court, Mr White was convicted, on his guilty plea, of an offence contrary to sections 64(1) and 67(2) of the Medicines Act 1968 in that he supplied a medicinal product in pursuance of a prescription which was not of the nature or quality specified in the prescription. He was subsequently given a four-month sentence of imprisonment suspended for two years.

ALLEGATIONS

19. Mr White did not attend before the Statutory Committee when it met in September 2017, nor was he represented. That Committee found the following allegations proved:

Misconduct:

1. *That on 6 February 2014 at Clear Pharmacy, Antrim Health Centre, you did dispense Propranolol 40 mg in circumstances corresponding to a retail sale in contravention of Section 58 (2)(a) of the Medicines Act 1968, in that you supplied a medicinal product which was not of the nature or quality demanded by the patient or in accordance with the presented prescription contrary to Section 64(1) of the Medicines Act 1968.*

2. *That you failed to follow the standard operating procedures established in the pharmacy in relation to (i) Assembly and Labelling, and (ii) Accuracy Checking.*

Criminal Conviction:

3. *That on 25 October 2016 at the Crown Court at Antrim you pleaded guilty to and were convicted of an offence contrary to Sections 64(1) and 67(2) of the Medicines Act 1968. The particulars of the offence state that on 6 February 2014 you supplied a medicinal product in pursuance of a prescription given by a practitioner which was not of the nature or quality specified in the prescription, to the prejudice of Patient A. You were sentenced on 16 December 2016 to imprisonment for 4 months, which was suspended for a period of 2 years.*

20. In addition, that Committee found that the allegations found proved amounted to misconduct.

IMPAIRMENT OF FITNESS TO PRACTISE

21. The Committee noted the findings of the previous Committee on the question of impairment of fitness to practise:

> ‘*33. By his actions, Mr White had created a risk which had resulted in the death of a patient under his care. By so doing, Mr White had breached fundamental principles of the pharmacy profession as set out in the Code and had brought the profession into disrepute.*

'34. ... There was also evidence that Mr White did not try to conceal his error and that he cooperated at all stages with the investigation by his employer into the tragic death of Patient A. He had pleaded guilty at the first available opportunity at the Crown Court. There was also some evidence, from Ms 1, that Mr White had shown insight into what had happened, albeit to a limited degree.

'35. The Committee was satisfied that a picking error of the sort under consideration was easily remediable. Robust personal training and reflection by a pharmacist to learn the lessons caused as a result of the error and supports put in place by an employer could be devised to avoid repetition. Unfortunately, in this case Mr White had chosen not to engage in this regard with the Committee either in person or through his legal representatives. As a result, the Committee had no meaningful evidence from Mr White, who is a practising pharmacist for over 25 years, to demonstrate his insight into the consequences of his error and an undertaking that, as a result of measures taken by him in his practice, such an error would not be repeated in the future. The Committee concluded, for these reasons, that there was a risk that the error could be repeated and that Mr White, in the future, could be liable to present a risk to the public, bring the pharmacy profession into disrepute and breach a fundamental tenet of the pharmacy profession.

'36. In addition, the Committee was satisfied that there was a strong public interest in making a finding of current impairment. The error, however unintentional, had resulted in the gravest consequence, namely the death of a patient in Mr White's care. The Committee considered that public confidence in the profession of pharmacy would be undermined if a finding of impairment, on public interest grounds, was not made.

'37. The Committee therefore finds Mr White's fitness to practise is currently impaired.'

22. The Committee had not been provided with any material from Mr White, since his suspension, which sought to demonstrate his insight into his failings at the material time in the period following the suspension order. Further, there was no evidence that Mr White had taken any effective steps to maintain his skills and knowledge in the pharmacy profession while suspended. Accordingly, the Committee was satisfied that Mr White's fitness to practise remained impaired. Further, given the serious nature of the misconduct identified, the Committee determined that it remained necessary to make a declaration of current impairment on public interest grounds as well.

23. The Committee therefore concluded that Mr White's fitness to practise remained impaired.

SANCTION

24. The Committee had regard to its powers on review of a substantive order, as prescribed by paragraph 7(3), Schedule 3 of the Pharmacy (NI) Order 1976 ('the Order'). In considering

what sanction to impose the Committee took account of the principle of proportionality and the need to balance the public interest against Mr White's interests. The Committee was also mindful that the purpose of any sanction was not to be punitive, but to protect members of the public, maintain public confidence in the profession and in the Society, and to declare and uphold proper standards of conduct and performance. The Committee also paid due regard to *The Statutory Committee – Indicative Sanctions Guidance,* published by the Society.

25. The Committee first considered whether it would be right to take no action and allow the current order of suspension to lapse. This was an inappropriate response given the Committee's findings in respect of current impairment. In addition, to the Committee's mind, such an outcome would be undesirable as it would enable the Registrant to return to unrestricted practise after the period of the suspension order had expired. To take no further action was also contrary to the primary purpose of a sanction in regulatory proceedings, namely, the need to uphold and maintain the public interest.

26. The Committee next considered whether to make Mr White's registration subject to conditions upon the expiry of the suspension order. Mr White had failed to engage in a meaningful manner with the Society since his suspension. He had failed to advance evidence to the Committee to demonstrate that he had acquired insight into his failings. He had taken no steps to assuage the concerns expressed by the previous Committee that he would not repeat the serious errors that had been found proved against him. Against that backdrop, the Committee could formulate no workable, enforceable or verifiable conditions that could attach to Mr White's registration that would adequately protect the public.

27. The Committee then turned to address the question of whether it should extend the suspension order currently in place for a further period. The Committee recalled the reasoning of the previous Committee, at the sanction stage, when addressing whether it would be appropriate to suspend Mr White's registration. That Committee observed:

> '*48. …Mr White had chosen not to directly engage with these proceedings. He had chosen not to attend before the Committee or be represented. The Committee drew no adverse inference against Mr White in respect of his decision but was left, as a result, with no meaningful evidence from him concerning his insight and the steps that he would take in his practice to ensure that an error which had resulted in Patient A's death would not be repeated. The Committee concluded that, as a result, it was necessary to apply a sanction which prevented Mr White to a greater or lesser extent, in the public interest, from practising as a pharmacist.*
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> *'49. The Committee carefully considered Mr White's actions on the date in question. He had admitted to supplying the wrong medication because of a selection or picking error. He had subsequently failed to undertake obvious and expected checks that could have had the potential to detect and correct the error in the dispensing process. The Committee carefully analysed Mr White's actions in the dispensing of Patient A's medication and the immediate aftermath. There had been an admission by Mr White*

to an error in the dispensing process. The error was an isolated incident in the otherwise unblemished career of an experienced and professionally well-regarded community pharmacist. Mr White had been open and transparent in connection with the investigation into the cause of Patient A's death. He had accepted the significance of his role in dispensing the incorrect medication to Patient A and had pleaded guilty in the criminal proceedings brought against him in respect of his error. He had also, through his legal representatives, made wholescale admissions at the outset of these proceedings. There was also some evidence that, to a limited degree, Mr White had insight into his failings. For these reasons, while it could be said that Mr White's actions were serious and had profound consequences, they could not properly be described, in themselves, as being fundamentally incompatible with continued registration as a pharmacist.

'50. ...Mr White [asserted he] would never again work as a pharmacist and that he found it impossible to conceive that he could practise again after the events which led to Patient A's death. The Committee noted this assertion, but reminded itself that its primary function was to protect and uphold the public interest. While Mr White's current stated position was of some relevance, the Committee at the sanction stage was required to act proportionately and to identify, in its judgement, the sanction which it considered adequately protected the public. The Committee concluded that the public interest, which included the protection of patients and the public, could be adequately safeguarded, at this stage, by the suspension of Mr White's registration.'

28. At paragraph [52] of the previous Committee's determination, Mr White was advised that any future review of the suspension order would be assisted by a reflective piece from Mr White which addressed his learning arising from the circumstances and consequences of the error which had resulted in the regulatory proceedings against him and those steps that he would take to prevent reoccurrence in the future. Mr White had chosen, for his own reasons, not to avail himself of that guidance. As a result, the Committee was left, in the intervening period from the date of his suspension, with no evidence that he had undertaken any remedial training or learning in order to avoid the risk of repetition of the behaviour complained of. Similarly, the Committee had no material on which to assess Mr White's insight into his actions which had culminated in Patient A's tragic death.

29. The Committee reminded itself that the application of a sanction was not a punitive measure and that it was dealing with a pharmacist who had, with the exception of these proceedings, an unblemished record of service as a pharmacist in a community setting for many years. However, in the absence of any basis that would give the Committee the necessary degree of reassurance that he would not, in the future, pose a risk to patients and the public, the Committee considered that extension of Mr White's current suspension order would serve no useful purpose. Mr White had not taken any demonstrable steps to remedy his failings. As a result, he presented a continuing risk to patients and the general public of repeating his misconduct. He had made plain that he had no intention of returning to the pharmacy profession and had chosen, as a result of his clearly expressed view to the Society and the Committee, not to engage in a meaningful manner with the regulatory process. In light of

these circumstances, the Committee concluded that the only proportionate and appropriate step to take which would protect and uphold the public interest was to direct the Registrar to strike-off the Registrant from the register with immediate effect.

ORDER

30. The Committee issued a direction to the Registrar that, in accordance with regulation 7(3)(a)(i) of the Regulations, the name of Mr Martin James White be struck-off the register kept in pursuance of Article 6 of the Order.

COSTS

31. There was no order for costs.

Conor Heaney
Chairman
18 May 2018