**STATUTORY COMMITTEE OF THE PHARMACEUTICAL SOCIETY OF NORTHERN IRELAND**

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| **In the matter of:** | Mr Martin James White (3062R) |
| **Location:** | Pharmaceutical Society of Northern Ireland's Offices, 73 University Street, Belfast, BT7 1HL |
| **Date:** | 25, 26 and 28 September 2017 |
| **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 |
| **Order:** | **Suspension Order 7 Months** |

1. The Committee met to consider allegations of misconduct and conviction against 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 1-370.

**SERVICE**

3. The notice of hearing, dated 8 August 2017, was sent to Mr White's registered address on the same date. This was in excess of the 35 days' notice required to be given 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 accordingly satisfied that service of the notice of hearing had been effected on Mr White in accordance with the Regulations.

**PROCEEDING IN ABSENCE**

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

5. The Committee considered document 'A', a letter from Mr White's legal representatives to the Society, dated 22 September 2017, which confirmed that Mr White did not intend to attend the hearing or be represented. Mr White in the letter, raised no issues of health to explain his non-attendance, nor had he asked for an adjournment to a later date in order to attend or be represented. The Committee could see no good reason to think that Mr White

would attend at a later date in any event. Mr White faced a serious allegation which involved the death of a patient in his care. The Committee considered that, given the nature of the allegations faced by Mr White and his clearly stated position, there was a strong public interest in proceeding to hear the matter in Mr White's absence.

**BACKGROUND**

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

7. Mr White was 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.

8. 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 (a steroid) were dispensed along with two other types of prescription medication.

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

10. 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.

11. 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.

12. 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 ('SOPs') then in force as issued by Clear Pharmacy.

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

14. 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**

15. Mr White faced the following allegations:

***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.*

**APPROACH OF THE COMMITTEE TO THE ALLEGATIONS**

16. The allegations to be considered by the Committee alleged impairment on two statutory grounds, namely, misconduct and conviction, arising out of the same factual background. The Committee decided, in order to ensure a fair hearing, to reach a determination on the misconduct ground first before considering the second conviction ground.

**DECISION ON THE FACTS/ ALLEGATIONS AND REASONS**

17. The Committee further considered document 'A', in which the facts as set out in the Notice of Referral were admitted. Accordingly, the facts were found proved by reason of Mr White's admission as contained in document 'A'.

18. The Committee considered document 'B', a letter from Mr White's legal representatives dated 22 September 2017 to the Society in which the hearing bundle was agreed and document 'C', a further letter from Mr White's legal representatives dated 22 September 2017 in which Mr White admitted misconduct. The Committee noted Mr White's admission but reminded itself that the question of whether Mr White had committed misconduct was a matter for the Committee in the exercise of its independent judgement.

19. Mr Shields made a submission to the Committee on the question of misconduct. He set out the relevant background and chronology which resulted in Mr White's dispensing error. The Committee heard that Mr White's actions arose as a result of a selection or 'picking' error which had resulted in a label being attached to the wrong medication which had then been dispensed to Patient A's husband and later ingested by her. Mr Shields submitted that, in spite

of being a single dispensing error, Mr White's actions had resulted in a catastrophic outcome and amounted to misconduct.

20. There was no evidence before the Committee that Mr White had acted in a deliberate, reckless or wilful fashion when he dispensed the wrong medication. He had been completely open and honest in accepting in subsequent enquiries that he had been responsible for incorrectly dispensing Propranolol against Patient A's prescription. Mr White had picked the wrong medication. There was evidence before the Committee that Propranolol and the correct medication had been arranged alphabetically in the dispensary, with no warnings in place to differentiate one from the other. The absence of an explicit requirement to have the medication finally checked by a second person had been changed by SOPs introduced to the pharmacy by Clear Pharmacy only a few days before the date in question. There was no evidence to confirm that they had been implemented by that stage.

21. The hearing bundle confirmed that Patient A had suffered from COPD. The prescription written on 6 February 2014 was the first occasion when the intended medication, Prednisolone, was to be dispensed to Patient A. Mr White had no contact with Patient A or her husband to offer patient advice prior to, or after, dispensing the medication. If this had occurred as it should have done, it would have provided an opportunity to identify the error. Mr White's actions, the result of human error, led in turn directly to Patient A's death.

22. The Committee was mindful that it was not being asked by the Society to determine that Mr White's actions amounted to misconduct because he had committed a picking error. The Committee was aware that such errors can occur in a busy pharmacy practice. The vast majority of these are picked up upon without untoward incident. Instead, in this case, the Committee was being asked to examine a picking error and the consequences of that error, namely Patient A's death. The Committee could think of no graver a consequence of such an error than the death of a patient who had been given the wrong medication. It was on that specific basis and in those particular circumstances that the Committee decided that Mr White's actions, in an isolated instance, amounted to misconduct and were serious.

23. In deciding that Mr White's actions had fallen short of the standards required to be adhered to by registered pharmacists, the Committee had regard to the Code of Ethics (2009) ('the Code'). In particular, the Committee determined that Mr White's actions as admitted and found proved had breached the following provisions of the Code:
    - The general principle of Registration as a pharmacist that requires you to act to promote and maintain public confidence in the pharmacy profession;
    - Principle 1 – Make the safety and welfare of patients your prime concern and in particular obligations 1.1, 1.2, 1.3, 1.4, 1.5 and 1.6;
    - Principle 4 – Exercise professional judgement in the interests of patients and public and in particular obligations 4.1 and 4.2;
    - Principle 8 – Provide a high standard of practice and care at all times and in particular obligations 8.1, 8.4, 8.7, 8.8 and 8.10.

24. The Committee found that Mr White's actions as admitted and found proved amounted to misconduct.

25. The Committee then considered the Certificate of Conviction. The Committee accepted that the Certificate was conclusive proof of Mr White's conviction before the Crown Court and the facts underlying the conviction.

**IMPAIRMENT OF FITNESS TO PRACTISE**

26. The Committee heard evidence from Ms 1, the Superintendent Pharmacist, from 2005 to present, of Clear Pharmacy. Ms 1 was fully acquainted with the facts and circumstances surrounding the dispensing error which had resulted in Patient A's death.

27. Ms 1 told the Committee that SOPs had been supplied by her on 3 February 2014 to the Clear Pharmacy where Mr White worked. Amongst other matters, the new SOPs had been amended to ensure that a final check should be undertaken by a second person prior to dispensing the medication and that self-checking should be countenanced only in exceptional circumstances. Ms 1 said that it would be usual to expect that new SOPs would take two weeks or so before full implementation. She conceded there would have been insufficient time to implement the new SOPs before the picking error had occurred which had resulted in Patient A's death.

28. Ms 1 said that after the subject incident, the SOPs were updated on two further occasions, in March and May 2014. The object was to enhance the accuracy and checking of prescribed medication. In addition, Ms 1 stated that Clear Pharmacy had introduced a system across the group that all beta blockers (including Propranolol) were segregated into a specific section in the dispensary to ensure that extra care was taken prior to selection. Audible and visual alerts had also been introduced on the computer system to highlight to prescribers that extra care and attention was needed before such medication was dispensed.

29. Ms 1 explained that, following the death of Patient A, Mr White was directed by his employer to no longer conduct accuracy checks and that he fulfilled administration and training roles within the pharmacy. A rota was introduced for checking purposes and a specific checking area was brought in with a pharmacist dedicated to checking medication, on a rotating basis, for no more than a few hours during the day.

30. On questioning by the Committee, Ms 1 confirmed that Mr White never questioned the restrictions placed on his practice by his employer nor did he ask for them to be changed. Ms 1 confirmed that Mr White fully realised the severity of what had happened with Patient A and the importance of his role in that regard. Due to issues connected with Mr White's health following Patient A's death and a phased return to work, combined with his resignation from Clear Pharmacy in January 2016, Ms 1 stated that it was difficult to conduct meaningful remedial work with Mr White. Ms 1 felt that, although he had completed some CPD with respect to medication errors and incidents, Mr White's insight into what had happened concerning Patient A's death was somewhat limited.

31. The Committee heard a submission from Mr Shields. He submitted that matters arising from Mr White's actions and the public interest required a finding of current impairment. Mr Shields drew the Committee's attention to those matters listed at (a)-(f) of the Statement of Case at page d of the hearing bundle in support of his submission.

32. The Committee had regard to those matters set out at regulation 4(2). The Committee derived guidance from the correct approach to be adopted to the question of whether Mr White's practise is currently impaired from the principles set out in the case law and, in particular, Cohen, Meadow and Grant.

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. Mr White had not, for his own reasons, submitted any documentary material for the Committee's attention at the impairment stage. He had agreed the hearing bundle. There was evidence contained within it that he had some health issues both before and after the error that had caused Patient A's death. Those issues, however, were not asserted by Mr White to have caused or contributed to the picking error which had resulted in the regulatory proceedings against him. 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.

**SANCTION**

38. The Committee considered document 'E', a letter from Mr White's legal representatives to the Society dated 22 September 2017. The letter set out the impact which Patient A's death had on Mr White, both personally and professionally. Mr White expressed remorse and regret for his actions. He indicated that he did not want to return to pharmacy and had previously requested that the Society grant his voluntary removal from the Register.

39. The Committee also heard further evidence from Ms 1, in relation to conditions at the pharmacy at the time of the dispensing error and the investigation by Clear Pharmacy into how Patient A's death had come about and Mr White's role in that.

40. Mr Shields made a submission to the Committee. He highlighted aggravating and mitigating features. He submitted that Mr White's actions, including his failure to abide by the expected process following the dispensation of the medication, represented a fundamental departure from the standards to be expected from a registered pharmacist. Mr White had not engaged and had expressed a clear intention that he did not want to work as a pharmacist in the future. Mr Shields submitted that all of these factors justified, on public interest grounds, a striking-off order.

41. The Committee considered the Society's Indicative Sanctions Guidance document (as approved by the Council of the Society on 25 July 2012) ('the Guidance'). In considering what sanction to impose, the Committee had regard to the principle of proportionality and the need to balance the public interest against Mr White's interests. The Committee also bore in mind that the purpose of a sanction was not to be punitive but to protect members of the public, maintain public confidence in the profession and the Society and to declare and uphold proper standards of conduct and performance.

42. The Committee first considered the seriousness of the conduct which Mr White had engaged in.

43. The Committee had regard to the aggravating factors as set out in the Guidance. Mr White's actions were directly connected to the profession of pharmacy and had occurred when he was discharging a basic function as a pharmacist on pharmaceutical premises. Mr White was the responsible pharmacist when Patient A's husband was supplied with the wrong medication. Mr White had failed to act in a manner that would have been professionally expected of him in a number of important aspects. Firstly, he had failed to properly ensure that the medication selected accorded with the prescribed medication. Second, he did not get a second person to check the prescription after it was dispensed. Third, he had failed to make contact with Patient A or her husband to offer advice either before or after the dispensing of the medication. Offering such advice would have been the expected given Patient A's condition and the fact that this was the first occasion on which Patient A had been prescribed Prednisolone. Mr White thereby missed a number of opportunities to identify that he had dispensed the wrong medication. Finally, Mr White's actions, whilst representing an isolated incident in an otherwise unblemished career, had resulted in grave and profound consequences, namely the tragic death of Patient A.

44. The Committee then had regard to the mitigating factors. Mr White had been engaged in the pharmacy profession on the date of the incident concerning Patient A, without incident, for the best part of 25 years. He had resigned from his position and in the course of his sentencing hearing in the Crown Court, the judge made reference to the fact at that time Mr White was unemployed and in receipt of benefits. Mr White had cooperated with the investigation conducted by Clear Pharmacy into the circumstances surrounding Patient A's death. Mr White admitted responsibility for the error which had resulted in Patient A receiving the wrong medication. He had pleaded guilty at the first opportunity at the Crown Court and had made admissions to the facts, misconduct and his conviction at the outset of these proceedings. There was some evidence that Mr White was insightful into the circumstances of Patient A's death, although this was to a limited extent.

45. The Committee then considered the sanctions available in ascending order of severity.

46. The Committee considered that it would be inappropriate to conclude the matter by giving Mr White a warning. None of the factors highlighted in the Guidance were applicable which would make a warning appropriate. In addition, the findings made in respect of Mr White's practice and the public interest weighed heavily against the giving of a warning which would permit him to return to unrestricted practice.

47. The Committee next considered imposing conditions on Mr White's registration. The Committee had no up to date information about Mr White's current employment. The Committee was aware that, towards the end of 2016, when he was sentenced in the Crown Court, Mr White was unemployed and expressed a clear desire that he did not want to return to pharmacy. In a case such as this, the Committee considered that it would be essential for a Registrant to have an engaged and supportive employer who would be willing to work in collaboration with a Registrant in order to demonstrate that there would be no repetition of the behaviour complained of. That feature was absent in this case. As a result, the Committee could not formulate workable, enforceable and verifiable conditions that would adequately protect the public.

48. The Committee next considered the suspension of Mr White's registration. There were references dating back to 2014 and 2016 from various healthcare and other professionals. These references had not been obtained in connection with the current proceedings but, nonetheless, the Committee attached considerable weight to their assertions that Mr White was a safe and effective clinician. 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.

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. The Committee had further regard to document 'E' in which it was asserted that Mr White 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.

51. The Committee considered those factors which would justify a striking-off from the Register. Mr White had breached the Code in a number of important aspects. The Committee was not persuaded that Mr White's actions, while serious, were fundamentally incompatible with continued registration or that public confidence in the pharmacy profession would be undermined by the imposition of a less restrictive sanction, in this case suspension. The Committee considered that, at this stage, striking-off would be a disproportionate sanction to apply.

52. The Committee considered that another Committee charged with reviewing the substantive suspension order would be assisted by the completion by Mr White of a reflective piece outlining his learning arising from the circumstances and consequences of the error which resulted in the proceedings against him and the steps that he would take to prevent reoccurrence in the future.

53. The Committee determined that it was appropriate to make the suspension order for a seven-month period. There will be a mandatory review before the expiry of the order. The Committee considered that this duration was a reasonable period within which to allow Mr White sufficient time to consider the reasoning of the Committee while, during that time, ensuring that the public interest was protected.

**INTERIM MEASURES**

54. The Committee imposed an interim measure to cover the appeal period or, if an appeal is lodged, to cover the period until the appeal is determined or otherwise finally disposed of. The Committee imposed the interim measure in order to protect the public and in public interest grounds.

**COSTS**

55. There was no order for costs.

**Conor Heaney**
**Chair**
**28 September 2017**