STATUTORY COMMITTEE OF THE PHARMACEUTICAL SOCIETY OF NORTHERN IRELAND

In the matter of:	Heather Trueick (2448R)
Location:	This hearing took place at the premises of the Pharmaceutical Society NI, 73 University Street, Belfast, BT7 1HL.
Date:	1st, 2nd and 20th December 2022, and 9th and 13th January 2023
Committee:	Mr Gary Potter (Chair), Mr Paul Archer (Lay), Mrs Liz Kerr (Registrant)
Persons Present and Capacity:	Ms Heather Trueick (Registrant), Mr Dennis Hamill Barrister instructed by Ms Rachael McAdorey Carson-McDowell (Registrant's Legal Representatives), Mr JonPaul Shields, Barrister, instructed by Ms Shannon McClintock, CFR Solicitors (PSNI's Legal Representatives), Mrs Laura Hughes Registrar, Ms Katie Quinn, BL, Legal Officer.

Service

1. The Committee satisfied itself that service of the Notice of Hearing was properly effected. The Notice of Hearing, dated 26th August 2022, was sent to the Registrant's registered address on the same date. The hearing was originally listed for the 3rd and 4th October 2022, but a postponement application, on behalf of the Registrant, was granted and the hearing relisted for the 1st and 2nd of December 2022. The Committee was satisfied that the notice provided was more than 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').

2. The Committee had before it a hearing bundle, numbering pages 1 – 199. The Committee also had before it a second bundle of pharmacy records, numbering pages 1-1578.

3. During the duration of the proceedings the Committee also considered the following documents:

Exhibit 1: Statement of Heather Trueick, dated 30th November 2022

Exhibit 2: Reflection of Heather Trueick, received 30th November 2022.

Exhibit 3: Statement of Carolyn O'Hagan, dated 30th November 2022.

Exhibit 4: Standards and Guidance for Internet Pharmacy Services in Northern Ireland, 2016.

Exhibit 5: Statement of Case on behalf of the Society, dated 25th November 2022.

Exhibit 6: Letter from Heather Trueick to Suzanne McKee, dated 30th March 2022.

Exhibit 7: Index and Bundle of Certificates, received on 19th December 2022.

Exhibit 8: Fitness to Practise Statement of Case on behalf of the Society, received 20th December 2022.

Exhibit 9: Determination of the Statutory Committee of the Pharmaceutical Society NI regarding Mrs Heather Trueick, dated 16th October 2020.

Exhibit 10: Determination of the Statutory committee of the Pharmaceutical Society NI regarding a review hearing concerning Mrs Heather Trueick, dated 11th May 2022.

Exhibit 11: Further Reflections of Heather Trueick (and appendices), dated 9th January 2023.

Exhibit 12: Submissions on behalf of the Registrant with regards to sanction, 9th January 2023.

PRELIMINARY LEGAL ARGUMENT

4. The Committee received no preliminary legal arguments.

ALLEGATIONS

5. The Registrant faced the following allegations:

1. On various dates on and between 18 November 2019 and 1st February 2020 you, as superintendent of Wynrose Limited, failed to ensure that records of private prescriptions were completed and retained properly and in a manner that complied with Regulation 253 of the Human Medicines Regulations.

2. On various dates on and between 18 November 2019 and 1st February 2020 you failed to ensure that you properly completed records of private prescriptions in a manner that complied with Regulation 253 of the Human Medicines Regulations.

3. On various dates on and between 18 November 2019 and 1st February 2020 you, as superintendent of Wynrose Limited, failed to ensure that the pharmacy's standard operating procedure was followed with respect to the recording of private prescriptions.

4. On various dates on and between 18 November 2019 and 1st February 2020 you failed to follow the pharmacy's standard operating procedure with respect to the recording of private prescriptions.

5. *On 23rd January 2020, as superintendent of Wynrose Limited, you caused, allowed, or permitted medicinal products other than medicinal products on a general sale list, ordered via an online platform, to be prepared and dispensed from McFaddens Pharmacy other than under the supervision and control of a pharmacist.*

6. *On 23rd January 2020, as superintendent of Wynrose Limited, you caused, allowed, or permitted medicinal products, other than medicinal products on a general sale list, ordered via an online platform, to be prepared and dispensed from McFaddens Pharmacy without the knowledge of the Responsible Pharmacist, Suzanne McKee.*

7. *On 23rd January 2020 as superintendent of Wynrose Limited, you failed to manage and secure the safe and effective running of the pharmacy business with respect to the supply of medicinal products, other than medicinal products on a general sale list, ordered via an online platform.*

8. *Other than at 7 above, on various dates on and between 18 November 2019 and 30 November 2020 as superintendent of Wynrose Limited, you failed to manage and secure the safe and effective running of the pharmacy business with respect to the supply of medicinal products, other than medicinal products on a general sale list, ordered via an online platform.*

9. *On various dates on and between 18 November 2019 and 30 November 2020 as superintendent of Wynrose Limited, you failed to put in place suitable arrangements to allow the safe and effective dispensing of medicinal products, other than medicinal products on a general sale list, ordered via an online platform.*

10. *On various dates on and between 18 November 2019 and 30 November 2020, as superintendent of Wynrose Limited, you caused, allowed or permitted various pharmacists engaged by the business to dispense medicinal products, other than medicinal products on a general sale list, ordered via an online platform:*

(i)without their normal prescriber, or general practitioner, being notified about the supply, and

(ii)where the medicinal product dispensed had a potential for abuse or dependency.

FACTS

6. On 1st December 2022, the Committee received submissions from Mr Hamill that the Registrant accepted the allegations in relation to allegations one, two, three, four, eight, nine and ten. Mr Hamill outlined that the Registrant was disputing the allegations, and the underlying facts, in relation to allegations five and six. In relation to allegation seven, Mr Hamill outlined that the Registrant accepted the general failings outlined in allegations eight, but not any specific failings connected to Ms McKee, as outlined in allegations five and six, and relating to seven, concerning events on 23rd January 2020.

7. On 2nd December 2022, the Society called Ms Suzanne McKee, the Responsible Pharmacist on duty at McFaddens Pharmacy on 23rd June 2020, to give oral evidence in relation to the disputed allegations. Ms McKee was questioned by the Mr Shields, was cross examined by Mr Hamill and was subject to a number of questions from the Committee. On 2nd December the Registrant called Ms Caroline O'Hagan, the Accuracy Checking Technician (ACT) working at McFaddens Pharmacy on 23rd June 2020. Ms O'Hagan was questioned by Mr Hamill, cross examined by Mr Shields and subject to a number of questions from the Committee.

8. Prior to adjourning on 2nd of December 2022, it was indicated to the Committee that Mrs Trueick would also give oral evidence in relation to the disputed allegations, on the reconvening of the hearing on 20th December 2022. On the 20th December 2022, Mr Hamill made submissions on behalf of the Registrant that the Registrant now admits allegations 5, 6 and 7, in the context of the specific events of the 23rd January 2020. As all the facts and allegations were then admitted at that stage, this meant that the Committee did not need to make any findings as to which facts it found proved, and which parts of the evidence it accepted.

9. The Committee had received a Statement of Case from the Society (Exhibit 5). The parties agreed that, subject to one change, which emerged during the oral evidence session, the facts, as outlined in paragraphs 1-21 of the Statement of Case are agreed as the facts of the case. The change related to Paragraph 15(e) and (f), which should read '32 private prescriptions were dispensed on 23rd January 2023' and not '35'.

10. The Statement of Case outlined the following facts:

1. The Registrant first registered as a pharmacist with the Pharmaceutical Society of Northern Ireland in 1988.

2. Since 2nd April 2003, following its incorporation, the Registrant was the Superintendent Pharmacist for Wynrose Limited until 30th November 2020. She has been the company secretary and a director of Wynrose Limited since 2003. During the relevant period there were 4 pharmacies within the Wynrose group.

3. In or around November 2019, Wynrose Limited started to dispense private prescriptions that were ordered online through an online platform operated by Better Health Limited. Better Health Limited offered an online prescription and pharmacy service. Patients could order medicines online, including prescription only medicines and Schedule 4 and 5 controlled drugs. Prescriptions were then issued by a GMC registered doctor. These were forwarded electronically to a pharmacy within the Wynrose Group, where the prescriptions were processed and medicines dispensed. Supplies were then made to patient's throughout the UK, using the postal service. Patients were given the choice to opt out of informing their own GP of the supply. This choice was available to all patients up until March 2020, and then available to patients in Great Britain.

4. The Registrant, as superintendent, authorised and permitted the business to facilitate the dispensing and supply of medication ordered through the online platform.

5. Prescriptions were processed through pharmacies operated by Wynrose Limited namely McFadden's Pharmacy at Duncairn Gardens between November 2019 and 6th February 2020 and Rosetta Pharmacy on Rosetta Road between 7th February 2020 and 9th September 2020.

6. Following the introduction of this service, which facilitated the supply of POMs and other medicines not on the general sales list, the Registrant, as Superintendent, did not ensure that records for private prescriptions were completed and retained properly. Regulation 253 of the Human Medicines

Regulations 2012 requires a person lawfully conducting a retail pharmacy, in this case the Registrant, to make a written or computerised record containing details of the supply. This record must be made, save in the case of an emergency supply, on the day of the sale or supply, or if that is not reasonably practicable, on the day following that day.

7. *Between 18th November 2019 and 1st February 2020, records for private prescriptions were not kept in accordance with Regulation 253. A significant number of transactions were not properly recorded. Although the service commenced in November 2019, the Private Prescription Log for BetterHealth prescriptions commenced from 10th January 2020, following an inspection by a Pharmacy Inspector. From 10th January 2020, a considerable number of entries were made to the Private Prescription Log covering supplies that had been already made in November, December and early January. New supplies made after 10th January 2020 were routinely entered late, and not in accordance with the 2012 Regulations. On the face of the Private Prescription Log, there were apparent inaccuracies or errors in relation to the date of supply of medication. By way of example, there were entries completed on 24th January 2020 and 27th January 2020 in the Private Prescription Log that reference a number of prescriptions as having been supplied on 25th December 2019 and 26th December 2019 when the pharmacy would have been closed. Other entries suggest further dispensing occurred when the pharmacy would have been closed.*

8. *Some entries, which were made by the Registrant, referenced supplies made by her on a Saturday from McFadden's Pharmacy when the premises were closed and the RP log reflected the closure.*

9. *Some entries into the Private Prescription Log were made by a non-pharmacist using the login details of a pharmacist giving the incorrect impression that the entries were completed by the pharmacist whose name appeared in the entry.*

10. *The records were not maintained in accordance with Regulation 253 and the accuracy and integrity of the information recorded in the Private Prescription Log appears compromised.*

11. *The Registrant completed some of the entries herself and, as a pharmacist, was involved in some Private Prescription transactions in early January which were not properly recorded in accordance with Regulation 253.*

12. *The Registrant had introduced a Standard Operating Procedure (SOP) on 1st August 2019 with respect to the dispensing and recording of private prescriptions. On various dates on and between 18 November 2019 and 1st February 2020 the Registrant, as superintendent of Wynrose Limited, failed to ensure that the SOP*

was (i) understood and (ii) adhered to by pharmacist and non-pharmacist employees.

13. *The Registrant, having introduced it, failed to follow the SOP herself with respect to the recording of private prescriptions.*

14. *A review of medication transactions on 23rd January 2020 for the online service revealed the following information -*

    A. *From a review of the Private Prescriptions and the Private Prescription Log, 35 private prescriptions were dispensed on 23/01/20 from McFaddens (32 were prescribed and dispensed on 23/01/20 and 3 were prescribed earlier, but dispensed on 23/01/20). Entries were made for the 32 prescriptions dated 23/01/20 in the Private Prescription Log on 27/01/20.*
    B. *The entries in the Private Prescription log were all noted in the log as having been made and completed by Jenna McBride, a registered pharmacist.*
    C. *On 23/01/20, 327 entries were made in the Private Prescription Log, on the face of the Log, by Jenna McBride, many dating back to November 2019.*
    D. *The RP on the 23/01/20 was Suzanne McKee, a locum pharmacist.*
    E. *Entries for prescriptions dispensed and supplied on 23/01/20 were not made in the Private Prescription Log on a contemporaneous basis.*

15.

    a. *Suzanne McKee was the RP at McFadden's Pharmacy on 23rd January 2020, working as a locum. A person she believed was an Accredited Checking Technician (ACT) was present in the pharmacy working on the private prescription service that was operating from McFadden's Pharmacy. When asked whether there was anything that the ACT needed the RP to clinically check with respect to the private prescription service, Ms McKee was informed by the ACT that she was organising paperwork. Heather Trueick arrived at the Pharmacy and Ms McKee was advised by the Superintendent that she was not involved in the online pharmacy service.*

    b. *The RP, Suzanne McKee was deliberately excluded from the dispensing process with respect to the private prescription service on 23rd January 2020.*

c. *Ms McKee did not know about any supplies made through the Pharmacy on 23rd January 2020 to patients who ordered via the online service. She did not make any entry into the PMR or the PP Log. As she was unaware of any dispensing or supply through the online service, she undertook no clinical check with respect to any such supply. As RP she was not involved in relevant dispensing activity within the pharmacy. Accordingly, medicines such as dihydrocodeine, codeine phosphate, solpadol, co-codamol, and zolpidem were supplied from the pharmacy without the knowledge or involvement of the RP.*

d. *The Registrant was aware that Suzanne McKee was excluded from oversight of this pharmacy activity and that specific dispensing activity in relation to private prescriptions was kept from her as RP.*

e. *32 private prescriptions were dispensed on 23rd January 2020.*

f. *As Responsible Pharmacist on 23rd January 2020, Ms Suzanne McKee did not supervise the dispensing of these 32 private prescriptions.*

g. *The Registrant, in her capacity as superintendent, caused, allowed or permitted medicines to be dispensed on 23rd January 2020 without the RP being aware of, or supervising, the activity, notwithstanding her express indication that any supply of medication ordered online was done by and under the supervision of the RP.*

16. *Jenna McBride was not working at McFaddens on 23rd January 2020. Her log in details were used by the ACT to make entries into the PP log. This misuse of login details occurred on more than one occasion.*

17. *For a period of approximately 1 year between 18th November 2019 and 30 November 2020, the Registrant allowed significant quantities of medicinal products, other than medicinal products on the general sale list, to be supplied through her pharmacy business which were ordered online via the Better Health platform.*

18. *The way in which the service operated, with patients supplying information remotely to a GP, with no direct communication possible between the pharmacist and the prescriber, with no real opportunity for patient / pharmacist interaction,*

and no access to comprehensive patient information, the ability of a dispensing pharmacist to undertake proper and effective clinical appropriateness checks was severely and negatively impacted.

19. The option, which appears to have been utilised regularly, for a patient to opt out of informing their own GP of the supply was available to all patients up until March 2020, and then available to patients in Great Britain. The ability given to a patient to opt out of informing the patient's normal GP of any online ordered supplies created an inherent risk to the patient when a supply was made in such circumstances.

20. The Registrant, as superintendent, allowed the business to be used to supply medicines of potential abuse and misuse with the inherent limitations described above. Many of the initial supplies involved controlled drugs up until 12th March 2020 when this activity ceased. The superintendent then assured the Society in June 2020 that all supplies of private prescriptions ordered online had ceased as of 21st June 2020. This activity continued, nonetheless, despite this assurance between July until September 2020.

21. The Registrant failed to provide a safe and effective service and failed to manage the safe and effective operation of the business with respect to the online dispensing service provided.

11. As the Registrant accepted the facts as set out in paragraph 10, the Committee found the facts proved by reason of that admission under Regulation 34(6) of the Council of the Pharmaceutical Society of Northern Ireland (Fitness to Practise and Disqualification) Regulations (Northern Ireland) 2012, (the Regulations).

12. Accordingly, the Committee found the allegations proved.

13. The Committee then moved to consider the issue of impairment of Fitness to Practise. The Committee received a Fitness to Practise Statement of Case, by the Pharmaceutical Society NI, Exhibit 8. The Committee received oral submissions from Mr Shields on behalf of the Society. Mr Hamill accepted that the facts proved amounted to misconduct and made no contrary representations to the Committee in relation to the question of impairment of the Registrant's Fitness to Practise.

DECISION ON IMPAIRMENT OF FITNESS TO PRACTICE

14. At the start of day three of this hearing, the Registrant admitted the facts in relation to all the allegations, one to ten, having initially disputed the facts in allegations five and six and in respect of the events on the 23rd January 2020, concerning allegation seven.

15. Misconduct has now been admitted by the Registrant. The Committee did receive a written statement concerning Fitness to practise on behalf of the Registrant. The Registrant has not made any contrary submissions concerning the question of impairment of fitness to practise.

16. The Committee is required to make an independent decision about whether the Registrant's fitness to practise is currently impaired.

17. In considering the question of impairment the Committee has considered the relevant case law in particular,

(a) In GMC –v- Meadow 2006 EWCA CIV1319 the Court of Appeal said,

"The purpose of FTP procedures is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practice. The (Panel) thus looks forward not back. However, in order to form a view as to the fitness of a person to practice today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past."

(b) In CHRE –v- NMC & Grant 2011 EWHC 927 the Court confirmed the test to be applied was a current, forward looking one, confirming the question that the committee has to ask itself and determine was:

"Is this registrant's current fitness to practice impaired?"

(c) Further, in Cohen –v- GMC the Court said,

"As assessment of current fitness to practice will nevertheless involve consideration of past misconduct and of any steps taken subsequently by the practitioner to remedy it;", and

"It must be highly relevant in determining if a doctor's fitness to practice is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated."

18. The Committee considered the provisions of Regulation 4(2) of the Council of the Pharmaceutical Society of Northern Ireland (Fitness to Practice and Disqualification) Regulations (N.I.) 2012 ("the Regulations"). They provide mandatory criteria that this Committee must have regard to when considering whether or not a person's fitness to practice is in fact currently impaired. Regulation 4(2) states;

"In relation to evidence about the conduct or behaviour of the registered person which might cast doubt on whether the requirements as to fitness to practice are met in relation to the registered person, the statutory 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 as defined in the standards, or
(d) Shows that the integrity of the registered person can no longer be relied upon."

19. The Committee noted that from April 2003 the Registrant was the Superintendent Pharmacist for Wynrose Limited, until the 30th November 2020. She has been the Company Secretary and a Director for Wynrose Ltd from 2003. She continues to practise as a pharmacist within Wynrose Limited.

20. In or around November 2019, Wynrose Limited started to dispense private prescriptions that were ordered online through an online platform operated by Better Health Limited. Better Health Limited offered an online prescription and pharmacy service. Patients could order medicines online, including prescription only medicines and Schedule 4 and 5 controlled drugs. Prescriptions were then issued by a GMC registered doctor. These were forwarded electronically to a pharmacy within the Wynrose Group, where the prescriptions were processed, and medicines dispensed. Supplies were then made to patients throughout the UK, using the postal service. Patients were given the choice to opt out of informing their own GP of the supply. This choice was available to all patients up until March 2020, and then only available to patients in Great Britain.

21. The Registrant, as Superintendent Pharmacist, authorised and permitted the business to facilitate the dispensing and supply of medication ordered through the online platform at McFadden's Pharmacy at Duncairn Gardens, between November 2019 and 6th February 2020, and Rosetta Pharmacy, on Rosetta Road between 7th February 2020 and 9th September 2020.

22. Following the introduction of this service, which facilitated the supply of POMs and other medicines not on the general sales list, the Registrant, as Superintendent Pharmacist, did not ensure that records for private prescriptions were completed and retained properly. Regulation 253 of the Human Medicines Regulations 2012 requires a person lawfully conducting a retail pharmacy, in this case the Registrant, to make a written or computerised record containing details of the supply. This record must be made, save in the case of an emergency supply, on the day of the sale or supply, or if that is not reasonably practicable, on the following day.

23. Between 18th November 2019 and 1st February 2020, records for private prescriptions were not kept in accordance with Regulation 253. A significant number of transactions were not properly recorded. Although the service commenced in November 2019, the Private Prescription Log for Better Health prescriptions only commenced from 10th January 2020, following an inspection by a Pharmacy Inspector. From 10th January 2020, a considerable number of entries were made to the Private Prescription Log covering supplies that had been already made in November, December, and early

January. New supplies made after 10th January 2020 were routinely entered late, and not in accordance with the 2012 Regulations. On examination of the Private Prescription Log, there were inaccuracies and errors in relation to the date of supply of medication. The Committee noted there were entries completed on 24th January 2020 and 27th January 2020 in the Private Prescription Log that reference a number of prescriptions as having been supplied on 25th December 2019 and 26th December 2019 when the pharmacy would have been closed. Other entries indicated that further dispensing occurred when the pharmacy was closed.

24. Further, on the 23rd January 2020, the Committee noted that 327 entries were made on the Private Prescription Log, on the face of the Log, by the ACT, using a registered pharmacist's log in details, many entries dating back to November 2019, providing an erroneous impression of who was in fact accountable for the safe supply of medication.

25. Some entries into the Private Prescription Log were made by a non-pharmacist using the login details of a pharmacist.

26. The records were not maintained in accordance with Regulation 253 and the accuracy and integrity of the information recorded in the Private Prescription Log was compromised.

27. The records also failed to comply with the Professional Standards and Guidance for Internet Pharmacy Services in Northern Ireland, in particular Standard 5.2, concerning the supply of medicines against prescription standards, and Standard 9, concerning record keeping.

28. The Registrant had introduced a Standard Operating Procedure (SOP) on 1st August 2019 with respect to the dispensing and recording of private prescriptions. The Registrant, having introduced it, failed to follow the SOP herself with respect to the recording of private prescriptions. On various dates on and between 18 November 2019 and 1st February 2020 the Registrant, as Superintendent pharmacist of Wynrose Limited, failed to ensure that the SOP was understood, and adhered to by her pharmacist and non-pharmacist employees.

29. For a period of approximately one year between 18th November 2019 and 30 November 2020, and for the avoidance of doubt including on 23rd January 2020, the Registrant allowed significant quantities of medicinal products, including controlled drugs specified in Schedule 2 of the Misuse of Drugs Act 1971 and Schedules 1 to 5 to the Misuse of Drugs Regulations (NI) 2002, to be supplied through her pharmacy business which were ordered online via the Better Health platform.

30. The way in which the service operated, with patients supplying information remotely to a GP, with no direct communication having been carried out between the pharmacist and the prescriber, with no evidence of patient / pharmacist interaction having occurred, and no access to comprehensive patient information, severely and negatively impacted upon the ability of a dispensing pharmacist to undertake proper and effective clinical appropriateness checks.

31. The option, which appears to have been utilised regularly, for a patient to opt out of informing their own GP of the supply was available to all patients up until March 2020, and then only available to patients in Great Britain. The ability given to a patient to opt out of informing the patient's normal GP of any online ordered supplies created an inherent risk to the patient when a supply was made in such circumstances, which the Registrant, as the Superintendent Pharmacist, should have recognised and taken the appropriate steps to minimise.

32. The Registrant, as Superintendent Pharmacist, allowed the business to be used to supply medicines of potential abuse and misuse in large quantities, with the obvious inherent limitations. Many of the initial supplies involved controlled drugs up until 12th March 2020 when this activity ceased. This was notwithstanding warnings given to her on 28th February 2020 by the Head of Pharmacy Medicines Management, within the then Health and Social Care Board (HSCB).

33. The Registrant then assured the Society in June 2020 that all supplies of private prescriptions ordered online had ceased as of 21st June 2020. Despite this assurance, this activity continued between July until September 2020.

34. The Committee considered the question of the Registrant's insight and did not think that the Registrant has shown demonstrable insight. There was a failure to pause and reflect upon the operation of online supply service. There was a failure to respond to clear warnings of potential harm. The resumption, and continuation of the service, after informing the society that it had ceased, showed particularly poor judgment, and a fundamental lack of insight. This was a considered and a deliberate act by the Registrant which the Committee considers was undertaken for commercial reasons. There continued to be a failure to fully acknowledge her failure in providing a safe and effective online service, and manage the safe and effective operation of the online dispensing service, which created a potential risk of real harm to patients.

35. The Committee's attention was drawn to the Registrant's relevant disciplinary history, and the Committee has taken this disciplinary history into account when considering relevant issues as to whether her misconduct is remediable, whether there is a risk of recurrence, and whether there is demonstrable insight.

36. The Committee noted that on on 16th October 2020 the Statutory Committee found that the Registrant's fitness to practice was impaired, and directed that the Registrant be the subject of a Conditions Order for 18 months. This direction of the Statutory Committee took effect on 14 November 2020. As part of the Conditions Order the Registrant was not permitted to retain the position of Superintendent Pharmacist. The Statutory Committee found in its determination of 16th October 2020 that Mrs. Trueick put commercial and business interests ahead of professional obligations. The Committee found that this approach is mirrored in this case. The Committee do note that following a review hearing in May 2022, the Statutory Committee decided not to extend the Conditions Order.

37. The Committee noted that during this time period the Registrant was subject to investigation by the Scrutiny Committee in December 2019. The Scrutiny Committee further referred the relevant matters to the Statutory Committee. During this time the online service was being operated by the Registrant.

38. In terms of assessing insight, the Committee took into consideration the Registrant's conduct during this hearing. Up until today, the Registrant disputed the facts in relation to allegations five, six, and partially in relation to allegation seven, concerning events

on 23rd January 2020. This approach resulted in a registered Pharmacist, and an ACT having to give evidence and be subject to cross examination.

39. The Committee did consider that Regulation 4(2)(a)(b) and (c) were engaged. In this case the Committee was invited to consider whether the facts as admitted demonstrated that the integrity of the Registrant can no longer be relied upon, thereby engaging Regulation 4(2)(d). The Committee's attention was drawn to the case of Wingate and Anor v SRA [2018] EWCA Civ 366, where the Court said:

> *In professional codes of conduct, the term "integrity" is a useful shorthand to express the higher standards which society expects from professional persons and which the professions expect from their own members. See the judgment of Sir Brian Leveson P in Williams at [130]. The underlying rationale is that the professions have a privileged and trusted role in society. In return they are required to live up to their own professional standards.*

40. The Committee noted the requirements of Principle 3 of the Code of Conduct, Ethics and Performance (2016), which were not met by the Registrant:

> *Principle 3 – Act with professionalism and integrity at all times and, in particular, standard 3.1 and the associated obligations set out below.*
>
> *Standard 3.1 – Act with honesty and integrity at all times.*
>
> *Standard 3.1.1 – Adhere to accepted and acceptable standards of personal and professional conduct at all times both inside and outside the work environment.*
>
> *Standard 3.1.2 – Maintain public trust and confidence in your profession by acting with honesty and integrity in your dealings with others. This applies to your professional, business and educational activities.*
>
> *Standard 3.1.7 – Make sure that any documents you complete or sign are not false or misleading, or contain false or misleading information. Take all steps*

that are reasonable necessary to ensure that recorded information is correct and complete. Do not omit relevant information

41. On the facts of this case the Committee concluded that her conduct did show that her integrity can no longer be relied upon. The Committee noted in particular:

a) Her actions were deliberate

b) Despite warnings from Mr Brogan, Head of Pharmacy and Medicines Management HSCB, on 28th February 2020, where he noted that:

"*for a number of cases, the GP has highlighted clinical concerns in relation to prescribing and supply of controlled drugs to their patients, because of therapeutic duplication and/or current instalment dispensing issues*",

the Registrant nevertheless continued to provide online services

c) On the 26th June 2020 the Registrant wrote to the interim Registrar of the Society stating:

"*I do not intend to restart dispensing controlled drugs through the online dispensing service. As of the 21st June 2020, Wynrose Ltd are no longer dispensing any online prescriptions for better health online ordering system and do not intend to recommence doing so*",

"*Wynrose Ltd are no longer dispensing any online prescriptions for Better Health online ordering system and do not intend doing so*".

d) She stated that from June 2020 she was going to cease the provision of online services. However, despite that undertaking she recommenced the provision of online services in July 2020, without notifying the Society and despite the previous concerns raised by the Head of Pharmacy and Medicines Management, HSCB. The resumption and continuation of these

online services, after informing the Society that they had ceased, demonstrated a fundamental lack of insight.

e) The Committee considered that this was a deliberate act by the Registrant conducted for commercial reasons. The Committee also noted that in the Registrant's statement to the Committee dated 30th November 2022, at paragraph 14, she said:

> *"In correspondence to the Society's Chief Executive and Interim Registrar, Mr Trevor Patterson dated 26th June 2020, I stated that Wynrose Limited had voluntarily ceased any online dispensing as of 21st June 2020, and did not intend to recommence doing so. Wynrose Limited did recommence the online pharmacy service for a short period of time between 15th July 2020 and 9th September 2020. This was done solely in order to meet a required contractual period of notice and was limited to the minimum period of time to meet that obligation".*

The Registrant's own words confirm, in the Committee's view, that her priority was to meet commercial obligations at the expense of her professional obligations.

f) The Committee noted that the manner in which she initially conducted her case attempted to divert blame from her onto the Responsible Pharmacist. At paragraph 22 of her statement of 30th November 2022, she said that the Responsible Pharmacist would have been aware of any medications being prepared or dispensed. The Responsible Pharmacist and the ACT both had to give evidence about events of the 23rd January 2020.

g) The Committee also noted that the Registrant had effectively conducted covert practices on the 23rd January 2020, without notifying the Responsible Pharmacist about what was going on.

h) The Registrant chose to engage in, continued, and recommenced online practices which facilitated the supply of medications online, without the necessary professional scrutiny.

i) The Committee considered that the Registrant's commercial interests prevailed over her professional obligations, which was in breach of the professional standards.

42. In the circumstances the Committee considers that the Registrant's fitness to practise is currently impaired.

43. For the avoidance of doubt the Committee also considered that it was in the public interest that there should be a finding of current impairment of fitness to practise.

DECISION AS TO SANCTION

44. The Committee is grateful for the detailed submissions on behalf of the Society, from Mr Shields, and on behalf of the Registrant, from Mr Hamill.

45. The Committee has reviewed the Indicative Sanctions Guidance and reminded itself that its decision must be proportionate.

46. The Committee acknowledges that the purpose of the sanction is not to be punitive, but to protect the public interest, and that the sanction it determines should impose no greater restriction on the Registrant than is absolutely necessary to achieve regulatory objectives.

47. The Committee is entitled to give greater weight to issues of public interest, and to the need to maintain public confidence in the profession, than to the consequences to the Registrant herself of the imposition of the appropriate sanction.

48. The Committee has to take into consideration issues of protection of the public, maintenance of public confidence in the profession and the maintenance of proper standards of professional behaviour.

49. As is required, the Committee considered all the potential sanctions available to it, starting with the lowest potential sanction, to decide which was the most appropriate and proportionate sanction in the circumstances of this particular case.

50. The Committee considered both relevant mitigating and aggravating circumstances.

51. As to mitigating factors the Committee took into consideration:

    a) The Registrant did demonstrate greater insight into her actions as the hearing progressed with the provision of a further reflective piece of 9th January 2023, through written submission from her Counsel, and by the admission of the facts in respect of all allegations. However, the Committee consider that the Registrant should really have been aware of the potential impact of her actions at the time, and certainly from when she received correspondence from the Accountable Officer, Mr Joe Brogan, on the 28th February 2020 in which he outlined patient safety and clinical concerns.

    b) The Committee was reminded that the Registrant had admitted most of the allegations at the start of this hearing, that she accepted that the facts giving rise to those allegations amounted to misconduct, and she did not challenge that the admitted facts amounted to impairment of her fitness to practise. The Committee acknowledge that the Registrant has now admitted all the allegations and that they amount to misconduct.

    c) The Registrant finally ceased the supply of medicines and medicinal products through an online service from the 9th September 2020, and has not recommenced that service to date, over two years later.

    d) The Registrant has now given a firm commitment to the Committee that she has no intention of resuming the supply of medicines and medicinal products through an online service in the future, and in such circumstances, the Committee considers that there is now no ongoing risk arising from this service.

e) The supply of medicines and medicinal products through the online services, which was the focus of this investigation, was a part of the pharmaceutical services that she offered through her pharmacies. There is no evidence that any other part of those pharmacy services provided to the public have been adversely impacted.

f) The admitted failures in respect of the pharmacies related solely to the supply of medicines and medicinal products through online pharmacy services.

g) The Committee considers that the risk of repetition of problems arising from the online services are now negligible.

h) The Registrant was previously made subject to a Conditions of Practise Order by a Statutory Committee on 16th October 2020, and on review of the Conditions Order on 10th May 2022, a Committee was satisfied that the Registrant had complied with the Conditions of Practise Order made.

i) The Registrant has kept up to date with her CPD.

j) The Committee noted that in her further reflective piece of the 9th January 2023, that she has instigated a number of checks and audits in her practices to ensure that appropriate record keeping is legally maintained and is in accordance with professional standards.

k) The Committee also notes that the Registrant instigated an audit to ensure the compliance of all personnel to her SOPs.

l) The Committee noted that the Registrant qualified as a pharmacist in 1987 and first registered with the Society in 1988, and that she became a Superintendent Pharmacist with Wynrose Limited in July 2000, becoming a director of that company in 2003 and is presently the sole Director of that company.

m) The Committee accept that it would not be in the public interest to end the career of an experienced pharmacist unless absolutely necessary.

n) The Registrant noted and accepted the Committee's fitness to practise decision on impairment, and that she displayed particularly poor judgement.

o) In her recent reflective piece the Registrant apologised for her actions, recognised the limitations of online dispensing, and the potential for harm to patients arising from her practice.

p) It was accepted that the Registrant had cooperated with the Society once the investigations got underway.

52. As to aggravating factors the Committee took into consideration that:

a) Despite receiving written concerns from the then Accountable Officer, Mr Joe Brogan, on 28th February 2020, as to patient safety and clinical appropriateness concerning the supply of medicines and medicinal products through the online service, the Registrant nevertheless continued to supply such products through this service.

b) On 26th June 2020 the Registrant notified the Interim Registrar of the Society that she did not intend to restart dispensing drugs through the online service from the 21st June 2020. In spite of this assurance, and with knowledge about written concerns from Mr. Joe Brogan as to patient safety and clinical appropriateness concerning the supply of medicines and medicinal products through an online service, the Registrant did recommence this online service again on the 15th July 2020 until the 19th September 2020.

c) The Registrant continued, stopped, and then recommenced the online services solely for commercial reasons at the expense of her professional obligations.

d) The Registrant chose to engage in, continued, and recommenced, online practices which facilitated the supply of medications online, when the Registrant knew these practices did not comply with the Society's "Professional Standards and Guidance for Internet Pharmacy Services (2009)".

e) The Committee was satisfied that the Registrant had breached a number of principles of the Code of Conduct, Ethics and Performance (2016), including Principle 1, Putting Patients First, Principle 2, Providing a Quality Service, and Principle 3, Acting with Professionalism and Integrity.

f) The Registrant's actions gave rise to a potential for harm to patients.

g) The Committee noted the previous regulatory finding against the Registrant, of 16th October 2020.

h) As Superintendent Pharmacist, the Registrant failed to inform the Responsible Pharmacist on 23rd January 2020, that online pharmacy services were being provided from McFadden's Pharmacy when she should have done.

i) The Registrant failed to comply with her own SOPs when providing this online service.

j) The Registrant's actions were deliberate and occurred over a prolonged period of time, specifically from the 18th November 2019 to the 21st June 2020 and again from the 15th July 2020 to the 9th September 2020.

k) The Registrant failed to keep accurate records when providing the online services from 18th November 2019 to 1st February 2020.

53. Addressing the potential sanctions available, the Committee first considered whether taking no action was appropriate. Given the Committee's findings on misconduct and fitness to practice impairment, quite simply, taking no action would not be proportionate or in the public interest.

54. Similarly, giving the Registrant a warning would, quite simply, not be proportionate or in the public interest. The totality of the facts that have been now agreed, and misconduct admitted, involved very serious matters, and gave rise to serious breaches of the professional standards.

55. If the Committee were to impose conditions, it is reminded that the conditions have to be workable in that they are appropriate to remediate the reasons for the Registrant's current impairment, that they have a realistic chance of being met by the Registrant, that they are capable of being verified by the Statutory Committee on completion, and that they are appropriate to protect the public. However, the Committee does not think that imposing conditions adequately reflects the seriousness of the facts as proved, nor are likely to be workable, or address public interest concerns.

56. The Committee then considered the sanction of suspension and whether this sanction would maintain public confidence in the pharmacy profession and be in the public interest. The Committee noted that a suspension may be required to highlight to the profession as a whole, and to the public in general that the conduct of a Registrant is unacceptable and unbefitting a member of the pharmacy profession. The Committee noted that suspension may be appropriate where the Committee considers that a registrant's impairment has been remediated or is remediable.

57. At the sanction stage, on the 9th January 2023, the Committee received the further reflective piece from the Registrant within which she demonstrated a greater insight into her actions and the potential impact that they could have had. She said that she fully understood the way in which the online service was set up could only lead to abuse of such a service to obtain medicines that were liable to be misused. She said that after listening to the evidence over the past few days of the hearing that she can now see how the Board and the Pharmaceutical Society had issues with how she managed the online prescribing services, that with her years of experience she should have been able to manage the whole process better, and should have paused and sought clarity on issues that could be seen as detrimental to the health and wellbeing of any patients using the service. However, the Committee did consider that the Registrant should have had this level of insight into her actions earlier. She did accept that her actions showed her lack of judgment, and that that it was unacceptable for someone in her position. She admitted that she let herself down, she let her team down, and that she let the pharmacy profession as a whole down as well as the public in general. She did offer an apology for her lack of insight and for her actions. She expressed embarrassment at allowing herself to be negligent at this time, during the

provision of the online services during which she was relying solely on the prescribing doctor to make clinical decisions on drugs that required special consideration due to their potential for misuse. She acknowledged that when challenged about the service in February 2020 that she should have ceased the service until all concerns had been addressed. She stated that if a similar situation arose in the future that she would have no hesitation in stopping the service until she was satisfied that she was given full assurances about public safety. She indicated that safeguards have now been put in place for private and HSC prescribing. She said that she took full responsibility for not understanding the severity of the communications received on the 28th February 2020 and for not acting on this communication. She accepted that her own SOP's were not followed during the relevant periods. She gave a reassurance that she would not recommence the online service at any time in the future. She said that she now saw the limitations of the online dispensing service and saw the potential harm that may be caused to patients that used the service.

58. The Committee considers that a finding that the Registrant's behaviour is fundamentally incompatible with being a registered professional, and that removing the registrant from the register is considered to be the only means by which the public can be protected and confidence maintained in the profession, is a very high hurdle. Whilst the Committee do consider that her behaviour was unacceptable, and unbefitting a member of the pharmacy profession, that she had breached a number of fundamental principles in the Code of Conduct and Standards, and that her conduct did demonstrate that her integrity could no longer be relied upon, the Committee are reminded that the supply of medicines and medicinal products through an online services was only one part of the pharmacy services that she had provided to the public. The Committee also took into account that she has now demonstrated some insight in her recent reflective piece, and through the written submissions on her behalf, has ceased the online services, has not recommenced those over the last 2 years or more, and has undertaken not to recommence such services again in the future. The Committee also took into consideration that the Registrant has had a career as a Pharmacist over approximately 35 years to date. The Committee acknowledged the words of Collins J. in Giele –v- General Medical Council 2005 EW8C2143 in which it was said;

"I do not doubt that the maintenance of public confidence in the profession must outweigh the interests of the individual doctor. But that confidence will surely be maintained by imposing such a sanction as is in all the circumstances appropriate. Thus in considering the maintenance of confidence, the existence of a public interest in not ending the career of a competent doctor will play a part."

59. For the reasons set out in its decision on impairment the Committee considers that the facts and the accepted misconduct is so serious that action must be taken to maintain public confidence in the profession and to protect the public. Having considered the totality of the evidence, and the submissions made at all stages of these proceedings, the Committee considers that the Registrant's conduct fell just short of being fundamentally incompatible with continued registration, and that the serious sanction of Suspension is one of the means by which the Committee consider that confidence can be maintained in the pharmacy profession, and the public can be protected.

60. The Committee considered that the sanction of Suspension for the maximum period of 12 months available to the Committee is the appropriate and proportionate sanction and is one which achieves the regulatory objectives of protecting the public, maintaining public confidence in the profession and maintaining proper standards of behaviour.

61. The Committee did seriously consider removal as the appropriate sanction. However, the Committee felt that the Registrant's behaviour, whilst very serious, was not in all the circumstances fundamentally incompatible with being a registered professional, and did not think that removing the Registrant from the register was the only means by which the Committee could protect the public and ensure the maintenance of confidence in the profession. Whilst there was a serious departure from the principles in the Code of Conduct, and that her integrity was found not to be reliable, nevertheless the Committee did not think that her behaviour was fundamentally incompatible with being a registered professional, and that removal was the only available sanction. As we have said above the Registrant has now demonstrated a limited degree of insight, she has apologised, and expressed remorse, she has ceased the online services, she has acknowledged the potential for danger arising from the online services, and she has acknowledged the potential harm to patients. The

Committee also take into consideration the fact that she has otherwise provided professional pharmaceutical services for approximately 35 years.

62. In deciding on a period of 12 months suspension the Committee took into account the gravity of the facts and the misconduct and the potential risks to patients, and that there were serious breaches of the fundamental principles in the Code of Conduct. The Committee expect that during the 12-month period that the Registrant can further reflect upon her actions and can work to providing and maintaining the highest professional standards going forward. The suspension will be reviewed by the Statutory Committee before the expiration of the 12 month suspension period.

INTERIM MEASURE

63. A period of 28 days is allowed for a registrant to lodge an appeal with the High Court. The decision of the Committee is not formally imposed until this period of appeal has formally ended or, where an appeal is brought, the date on which the appeal is fully disposed of. If the Committee considers that it is in the public interest to do so, it has the power to impose 'interim measures' until the appeal period is over or, if an appeal is successfully lodged, until the appeal has been fully disposed of.

64. The Committee noted that the Society did not make any submissions in favour of imposing an interim measure to cover the appeal period. The Committee further noted that the Society had not sought an Interim Order in this case. The Committee noted that whilst interim measures are usually imposed in cases where there are public safety concerns, should the registrant be allowed to continue to practise, the Committee notes that interim measures can be imposed on public interest grounds. Whilst the Committee did acknowledge that the risk to the public was reduced by the discontinuation of the online pharmacy service, the Committee did consider that in light of the serious nature of the findings in this case, and given the importance of sending a consistent message that the Registrant's actions and behaviour were unacceptable and unbecoming of a pharmacy professional, that it was in the public interest to impose an interim measure of suspension, covering the appeal period, in this case. The Registrant will therefore be suspended for the duration of the 28-day appeal period, or if an appeal is brought, up to the date when that appeal is fully disposed of.

COSTS

65. Pursuant to Regulation 48 of the Regulations, the Society served on the Secretary to the Committee a Schedule of Costs on 19th December 2022. On the 13th January 2023, the Committee received oral submissions from Mr Shields outlining that the Society and the Registrant had subsequently reached an agreement on Costs, whereby the Registrant had agreed to pay 25 per cent of the costs of the hearing, which amounted to £5000 plus VAT. Mr Shields indicated that this figure reflected the day long oral evidence session, resulting from certain facts of the case being initially disputed. Mr Hamill confirmed this position in his submissions.

66. The Committee considered the position reached by the parties to be proportionate and a reasonable approach considering how the hearing was conducted by both parties.

67. In this regard, the Committee made a Costs Order that the Registrant should pay Costs of £5000 plus VAT. This sum is to be paid within 28 days of the hearing.

Gary Potter

Chair of the Statutory Committee

13th January 2023