STATUTORY COMMITTEE OF THE PHARMACEUTICAL SOCIETY OF NORTHERN IRELAND

In the matter of:	JEFFREY REANEY (2317)
Location:	This hearing took place at the premises of the Pharmaceutical Society NI, 73 University Street, Belfast, BT7 1HL.
Date:	7th and 8th September 2023
Committee:	Gary Potter Bl (Chair), Dr Mark Timoney (Registrant Member) and Derek Wilson (Lay Member)
Persons Present and Capacity:	Keith Farrell, Solicitor, Campbell and Caher Solicitors, on behalf of the Registrant, Mr JonPaul Shields, Barrister, instructed by Ms Caitlin Brown, CFR Solicitors (PSNI's Legal Representatives), Mrs Laura Hughes Registrar, Ms Bronagh Conlon, Paralegal.

SERVICE

1. The Committee satisfied itself that service of the Notice of Hearing was properly effected. The Notice of Hearing, dated 01 June 2023, was sent to the Registrant's registered address on the same date. 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 – 378.

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

Exhibit 1: Statement of Case (the Society)

Exhibit 2: Fitness to Practise Submissions (the Society)

Exhibit 3: Statement of Case (the Registrant)

Exhibit 4: Prescriptions / PMR / RP Log Reconciliation

Exhibit 5: CPD and Retention Records

Exhibit 6: Email correspondence between Registrant's Solicitor and the Society

PRELIMINARY LEGAL ARGUMENT

4. The Committee received an application under Regulation 43 to remove the original seven allegations and replace them with five allegations. This application was made with the consent of the Registrant's legal representative. The Committee agreed to the application and the five allegations appear below.

ALLEGATIONS

5. The Registrant faced the following allegations:

    1. On various dates on and between 1 April 2017 and 31 December 2018, you submitted, or you caused, allowed or permitted to be submitted, claims for payment for dispensing of Mezolar to Patient A when no such medication was in fact dispensed.

    2. On various dates on and between 1 April 2017 and 31 December 2018, you had no proper or effective system in place to correctly identify items on a received prescription which should not be dispensed and to then code those items as having not been dispensed.

    3. On various dates on and between 1 April 2017 and 31 December 2018, you submitted, or you caused, allowed or permitted to be submitted, claims for payment for dispensing Mezolar to Patient A when you knew that no such medication was in fact dispensed and this represents a fundamental and systemic failure of management and control by you and a substantive breach of integrity.

    4. Knowing that Mezolar, a Controlled Drug, was a discontinued medication for Patient A, you failed to put in place, or have, any sufficient mechanism or procedure to ensure that (i) the GP stopped sending prescriptions containing Mezolar, and (ii) that a contemporaneous record was kept of contact with Patient A's GP.

5. You failed to ensure the safe and effective operation of a pharmacy in that you (a) failed to properly supervise and control the management of an inappropriately prescribed controlled drug, and (b) failed to complete and retain records after a patient medication intervention had occurred.

FACTS

6. At the hearing, the Committee received submissions from Mr Farrell that the Registrant accepted the allegations as outlined above.

7. The Committee received a Statement of Case from the Society (Exhibit 1). The parties agreed that the circumstances as laid out in paragraphs 1-21 of the Statement of Case are agreed as the facts of the case.

8. The Statement of Case outlined the following facts:

   i. The Registrant is currently a registered pharmacist in Northern Ireland. At the relevant time, he was the superintendent of VE Reaney Chemist Ltd which operated as Reaney Chemist, 12 Lisburn Street, Hillsborough, BT26 6AB.

   ii. On 31 August 2020, Mr. Jeffrey Reaney ("the Registrant") declared to the Pharmaceutical Society of Northern Ireland ("the Society") [redacted]

   iii. [redacted] the matter was progressed as a professional regulatory issue.

   iv. A Pharmacy Inspector undertook an investigation which revealed that prescriptions were written by a GP at the Hillsborough Health Centre between 25th March 2017 and 15th May 2018 with respect to one patient. The patient involved was the Registrant's mother. These prescriptions were processed through Reaney Chemist and were then submitted to BSO, by the Registrant, for payment. The implicit assertion flowing from submission for payment was that supplies had been made on foot of these prescriptions. Out of 17 prescriptions that were examined, only 2 had a

corresponding controlled drug register entry for Fentanyl / Mezolar. 15 apparent supplies of Fentanyl / Mezolar were not accounted for in the respective controlled drug registers. Effectively, insufficient purchases had been made from wholesalers to support the apparent supplies.

v. The investigation concluded, based upon an examination of the submitted prescriptions, that the 15 asserted supplies of Fentanyl / Mezolar had not been made.

vi. Mezolar had been discontinued for the patient in April 2017 and changed to Butec. This change was notified by the prescribing GP, Dr Rosemary Eames, to the Registrant by telephone on 10th April 2017. Mezolar patches were to stop and Butec patches used instead.

vii. Butec patches only should have been supplied from 10th April 2017.

viii. Prescriptions were received by the pharmacy that contained the item Mezolar for dispensing after 10th April 2017. These prescriptions were dated on and between 27/04/2017 and 15/05/2018. Sometimes Mezolar appeared on the prescription on its own, and sometimes it appeared with Butec on the same prescription.

ix. On 11 occasions, on and between 27/04/2017 and 15/05/2018, prescriptions were submitted for payment. There were 15 instances when it was claimed that the item Mezolar was supplied through the pharmacy when it was not, in fact, supplied. The prescriptions were coded for medication that was not provided and additional dispensing costs claimed for dispensing services not undertaken. These coded prescriptions were then sent to the BSO for payment and payment was thereafter made.

x. The Registrant has accepted that Mezolar was not incorrectly supplied to the patient but incorrectly claimed as having been supplied. The CDR reconciliation undertaken fairly establishes that there was no supply of Mezolar to the patient after it was discontinued on 10/04/17.

xi. It has not been possible to establish that the Registrant, or the pharmacy over which he was superintendent, requested from the GP's surgery (Hillsborough Health Centre) that Mezolar be supplied for the patient during the relevant period after it was discontinued.

xii. The Committee will not be asked to make a determination against the Registrant in this regard.

xiii. A reconciliation of the submitted prescriptions, the pharmacy's PMR and the pharmacy's RP log establishes that there were numerous occasions when the Registrant would have been responsible for the management of prescriptions arriving into the pharmacy for his mother which included, in error, the controlled drug Mezolar.

xiv. As only Butec was dispensed after 10th April 2017, it was clearly identified within the pharmacy that the patient should not be receiving both medications, and that any prescription that contained Mezolar was incorrect in this regard. Some prescriptions contained only Mezolar and some contained both medications.

xv. There should have been effective communication by the Registrant with the surgery to prevent scripts arriving at the pharmacy for over a year incorrectly containing Mezolar. Any interventions in this regard should also have been recorded. No contemporaneous record was made, or caused to be made, by the Registrant, of any contact with the GP surgery notifying the GP of the error or raising the issue with the GP.

xvi. No contemporaneous coding occurred when an item (the controlled drug Mezolar) was identified as incorrectly included on a prescription to mark the item as having not been dispensed. In this way, prescriptions that contained both Butec (authorised and dispensed) and Mezolar (unauthorised and not dispensed) were collectively coded and submitted for payment.

xvii. Further, there was no system in place to isolate a prescription which only contained an erroneous item, in this case Mezolar, and ensure that the prescription was not included in a batch for coding or submission for payment. Prescriptions containing only Mezolar were thereby coded and submitted for payment.

xviii. There was no proper procedure to properly handle the receipt of a prescription for a discontinued medication.

xix. The Registrant did not follow his own SOP with respect to record keeping for discontinued medication or changes to medicines.

xx. The Society does not accept that the incorrect coding of Mezolar and submission for payment was an "administrative error". 11 prescriptions arrived into the pharmacy on and between 27/04/17 and 15/05/18 containing the controlled drug Mezolar. The prescription was checked and Mezolar was not dispensed. The GP was not effectively informed to cancel this item over the course of just over a year. All of these prescriptions were miscoded as having been dispensed and submitted for payment. The Society is prepared to accept that that the Registrant was not dishonest but that there was a fundamental and systemic failure of management and control by him in this regard. Whilst not dishonest, it does represent a substantive breach of integrity.

xxi. The total amount that was claimed incorrectly by the Registrant has now been confirmed as £411.54.

9. As the Registrant accepted these facts, 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).

10. 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 2, and written submissions on behalf of the Registrant, Exhibit 3. The Committee also received oral submissions from Mr Shields on behalf of the Society and from Mr Farrell on behalf of the Registrant.

DECISION ON IMPAIRMENT OF FITNESS TO PRACTISE

11. In this case, misconduct has been admitted by the Registrant through his solicitor.

12. As to impairment of fitness to practise, the Committee has considered relevant case law, and in particular:

(a) In GMC –v- Meadow 2006 EWCA CIV 1319, 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 2008 EWHC 581 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."

(d) The Committee's attention was also drawn to Paragraph 21 of Yeong -v- GMC (2009) EWHC 1923, where Sales J stated:

"It is a corollary of the test to be applied and of the principle that a FTPP is required to look forward rather than backward that a finding of misconduct in the past does not necessarily mean that there is impairment of fitness to practise - a point emphasised in Cohen v General Medical Council [2008] EWHC 581 (Admin) at 63-64 (Silber J), and Zygmunt, at 31. In looking forward, the FTPP is required to take account of such matters as the insight of the practitioner into the source of his misconduct, any remedial steps which have been taken and the risk of recurrence of such misconduct. It is required to have regard to evidence about these matters which has arisen since the alleged misconduct occurred: see Cohen, at 69 to 71, and Azzam v General Medical Council [2008] EWHC 2711 (Admin) at 44, 105 BMLR 142 (McCombe J)."

13. Submissions on current impairment were received on behalf of the Society from Mr Shields, and on behalf of the Registrant from Mr Farrell. Whether or not submissions had been made to the Committee, the Committee is nevertheless required to make an independent decision about whether the registrant's fitness to practise is impaired.

14. In this case, the Committee was informed that –

(i) The Registrant was the superintendent of the business and often held the position of Responsible Pharmacist (RP).

(ii) The Registrant dealt with prescriptions for a patient, who was his mother.

(iii) The Registrant, for approximately a year between 27/04/2017 and 18/05/2018 received prescriptions on 11 occasions for medication, Mezolar, which is a schedule 2 controlled drug. This medication was discontinued for the patient, a fact that the Registrant knew. No supplies were made on foot of these prescriptions.

(iv) The prescriptions were coded to reflect a supply of Mezolar which had not occurred. The coded prescriptions were then submitted for payment to the BSO, and payment was duly made.

(v) There was no effective mechanism or system within the pharmacy to mark prescription items as not dispensed and no effective procedure to isolate prescriptions to prevent them being coded as having been dispensed when this had not occurred.

(vi) There was no effective communication with the GP surgery to prevent the erroneous issuing of Mezolar scripts for nearly a year and no records kept by the Registrant to reflect any such interventions that may have occurred.

(vii) There was a fundamental and systemic failure of management and control by the Registrant with regard to (v) and (vi) above.

(viii) Whilst not dishonest, his conduct does represent a substantive breach of integrity.

(ix) The loss occasioned was relatively modest (£411.54) but this does not diminish the gravamen of the misconduct.

(x) The Registrant appears to have been involved in most of the transactions personally, so the failings are his and not just a failure to establish a process for someone else to follow. It was submitted that it is not possible to say that he was involved in all of the transactions as there appear to have been occasions when other pharmacists were identified on the RP log as in control of the pharmacy at or about the relevant time.

(xi) No harm appears to have been occasioned to the patient as no Mezolar medication was, in fact, dispensed. A potential risk of harm remained given that erroneous scripts continually arrived at the pharmacy and vigilance would have been required by

someone other than the Registrant to identify Mezolar as an incorrect item for the patient.

15. The Committee was invited to consider any steps that have been taken by the Registrant to remediate and consider whether the Registrant has insight into the source of his admitted failings, whether there has been any effective remediation and whether there is any risk of recurrence.

16. The Committee was also invited to consider the wider public interest when determining the question of impairment. The Committee accepts the submissions that it is entitled, and indeed obliged, to have regard to the public interest in the form of (a) upholding standards and (b) maintaining public confidence in the pharmaceutical profession generally and, in the case of this individual pharmacist in particular, when determining whether the admitted behaviour currently impairs the fitness to practise of this Registrant.

17. Cox J, in the Grant case, set out the relevant position:

> *"In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances."*

18. The Committee also had regard to Regulation 4 (2) of the Council of the Pharmaceutical Society of Northern Ireland (Fitness to Practise and Disqualification) Regulations (Northern Ireland) 2012. The Committee accepts that this regulation provides mandatory criteria that this Committee must have regard to when considering whether or not the Registrant's fitness to practise is currently impaired. Regulation 4(2) provides:

"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 practise 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 also had regard to the relevant provisions of the Code of Professional Standards of Conduct, Ethics and Performance for Pharmacists in Northern Ireland (2016) ('the Code').

20. Having considered all of the material put before it, including the Registrant's statement, and submissions from both sides, the Committee finds that the Registrant's fitness to practise is currently impaired.

21. The Committee finds that:

(i) The Registrant failed to adhere to his own basic systems in dispensing prescriptions to Patient A;

(ii) The Registrant failed to clarify the prescriber's intentions, giving rise to a potential risk of harm to Patient A at the time;

(iii) Whilst the GP practice may not have been without criticism, nonetheless, the Registrant should have complied with his own professional obligations as a registered pharmacist and returned the prescription to the GP surgery to be corrected at the first opportunity;

(iv) Whatever contacts the Registrant was making with the GP practice proved clearly ineffective, yet he took no steps to rectify the problem;

(v) If the Registrant had returned the prescription for Mezolar to the GP practice for correction at the first opportunity, it is likely that none of the issues that subsequently arose would have occurred.

(vi) The Registrant claimed for reimbursement for medicines which he had not in fact dispensed.

(vii) These failures occurred over a prolonged period of time, from April 2017 to May 2018, on approximately 15 occasions.

22. It is accepted by the Registrant that he submitted, or caused, allowed or permitted to be submitted, claims for payment for dispensing Mezolar when the Registrant knew that no such medication, in respect of his mother, was in fact dispensed. The Committee agrees that this represents a fundamental or basic, and systemic, failure of management by him.

23. In his detailed statement to the Committee, dated 31 August 2023, the Registrant said that Patient A's medication was clearly known to him as he was intimately involved in his mother's care. Whilst he said that he was perhaps over-familiar with his mother's medication, he nevertheless had basic professional obligations to comply with and he ought to have complied with those obligations, and his SOPs to avoid him being in the position where he claimed monies for medications which were not in fact dispensed.

24. Whilst the Registrant's statement demonstrates insight, and the remedial steps which he has taken, and that there may be no material risk of recurrence, nonetheless the Registrant minimised his role in the relevant events to a degree, with a tendency to place blame on the GP practice rather than focusing on his own professional obligations.

25. The Committee accepts that there was no actual harm to Patient A. However, there was at the time a potential risk of harm to that patient. Insofar as the admitted facts demonstrated a fundamental and basic systemic failure of management concerning this patient, the facts as proved have brought the profession of pharmacy into disrepute.

26. He has breached some of the fundamental principles of the profession of pharmacy, including the following provisions of Code of Professional Standards of Conduct, Ethics and Performance for Pharmacists in Northern Ireland:

    2.1.2 Effectively control and manage the sale or supply of medicinal and related products paying particular attention to those with a potential for abuse or dependency.

    2.1.6 Ensure that you do not, whether by your actions or omissions, create a risk to patient care or public safety.

    2.1.11 Avoid treating yourself or anyone with whom you have a close personal relationship except for minor ailments or in an emergency.

    2.1.12 Ensure you are aware of and adhere to all relevant legislation, and all current standards and guidance which apply to your practice.

    2.3.1 Complete records promptly or as soon as reasonably practicable after the patient intervention or activity has occurred.

    2.3.3 Ensure all entries in any record are accurate, clearly and legibly written and attributable.

    3.1.7 Take all steps that are reasonably necessary to ensure that recorded information is correct and complete. Do not omit relevant information.

27. The Committee also considers that the wider public interest demands a finding of impairment, and that it is in the public interest that there is such a finding.

28. The Committee does accept that there was no evidence of dishonesty in this case. Further, the Committee was informed that the Registrant has enjoyed an otherwise unblemished, lengthy career as a registered pharmacist.

DECISION AS TO SANCTION

29. The Committee is grateful for the further detailed submissions on behalf of the Society, from Mr Shields, and on behalf of the Registrant, from Mr Farrell.

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

31. 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.

32. 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 himself of the imposition of the appropriate sanction.

33. 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.

34. 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.

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

36. As to mitigating factors the Committee took into consideration that:

    a. The Registrant had worked as pharmacist from 1985 without any blemish on his professional practice.

    b. When the events came to light the Registrant co-operated with the Pharmacy Inspector, [redacted] and the Society.

    c. The documentary evidence and submissions made demonstrate considerable insight into the errors that he made.

    d. The Registrant took appropriate remedial steps to amend his SOPs which the Committee had the opportunity to review.

    e. The Registrant made full restitution of all funds to the BSO.

f. The Registrant apologised for his actions and expressed remorse in his statement about the impact of his actions on the profession and the public perception of his admitted actions.

g. The Committee considered to be of particular note, in assessing the risk of recurrence, that the Registrant continued to practice from May 2018 to the time that he sold his practice at the end of 2021 without any further blemish on his professional practice as a pharmacist.

h. The Committee has taken into consideration the totality of the Registrant's written statement of the 31 August 2023, and highlights paragraphs 22, 23 and 24, in particular, which state:

"I accept that my failure in audit processes allowed this to occur and I accept that such conduct impaired my fitness to practise and would lead to the public confidence in the profession being diminished".

"In response to this I would say that I have practised safely since the 01 August 1985. My misconduct did not require the immediate intervention of the Society by way of any Interim Orders. I have co-operated fully at each stage with all statutory and regulatory bodies. I recognise that my misconduct will affect public confidence in the profession. I accept that while there was never any danger to the public my conduct was such as to amount to an impairment of my fitness to practise and as such should be marked by the Statutory Committee. On being made aware of the exact nature of the accusations I have taken the appropriate remedial action and amended both my policies and practices. The Committee can take heart from my practice without incident in the years since this misconduct came to light without any further concern on the part of the Society, my repayment of the sum erroneously claimed, my waiving of procedural defects and wish to get this matter to an early conclusion".

"I am truly sorry for placing myself in such a predicament at the end of career in a profession that I cherish. I trust that others will learn from my experience and do not repeat any mistakes that I made".

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

a. The nature and seriousness of the misconduct admitted involving prescriptions for controlled drugs to patient A.
b. The period over which the misconduct occurred, between April 2017 and May 2018.
c. The fact that the misconduct was not a one off isolated event, but occurred on approximately 15 occasions in respect of patient A.
d. Whilst there was no actual harm to patient A there was a potential for harm at that time.
e. There was a fundamental, and basic, systemic failure of management by the Registrant.
f. Claims were made for payment for medications which had not in fact been dispensed.
g. The Registrant breached relevant principles and obligations contained in the professional standards of conduct, ethics and performance for pharmacists.

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

39. The Committee considered whether giving the Registrant a Warning was an appropriate sanction. The Committee did consider that a Warning was the most appropriate and proportionate sanction based on the evidence and submissions it had received. A Warning would demonstrate to the Registrant, and more widely to the profession as a whole, and to the public, that his conduct fell below the standards expected of a pharmacist. In his detailed statement, the Registrant showed considerable insight, that he had taken remedial action, and continued to work, and provide professional services to the public from May 2018 to the selling of his business at the end of 2021.

40. The Committee felt that there was sufficient evidence before it of his intention to retire. Whilst it remains possible that the Registrant may seek employment as a pharmacist in the future, the Committee considered the following matters as being indicative of his future intentions:

a. On 30 November 2021, the Registrant resigned as director of his pharmacy business.

b. By 11 March 2022, approximately three months after he sold his pharmacy business, he informed his doctor that he was a local pharmacist who is now retired.

c. At the sanction stage the Committee was provided with a number of emails between the Registrant's solicitor and the Society. On the 19 May 2023, the Society were informed in an open email, "he is retired and has sold his practice and does not wish to remain on the Register". The Society responded appropriately indicating "while we understand Mr Reaney is now retired, we are unable to remove him from the Register while he is subject to fitness to practise proceedings".

d. The Committee received oral submissions from the Registrant's solicitor confirming that the Registrant intends to apply to remove his name from the Register once these proceedings are completed.

The Committee considers this evidence, in particular the content of the email of 19 May 2023, as being indicative of the Registrant's intention concerning practice in the future.

41. 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. Given that the Registrant has sold his pharmacy business in late 2021 and has indicated a clear intention to voluntarily remove his name from the Register, the Committee does not consider that any conditions that it may impose would in fact be workable.

42. 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. Having considered all of the issues in this case, the Committee did not think that a suspension would be appropriate or proportionate on the facts of this case.

43. As to removal from the Register, the Society quite properly did not pursue that as a fair and proportionate sanction.

44. The Committee did explore whether Undertakings from the Registrant might be an appropriate way of disposing of this case. However, having considered the submissions of both legal representatives, and having reflected on the relevant issues in the case, the Committee determined that the most appropriate and proportionate approach to the case was to impose a sanction of a Warning, the wording of which appears in the Schedule of this decision.

COSTS

45. No cost application was made.

SCHEDULE

WARNING

The Statutory Committee has issued a Warning in respect of the Registrant's need to reflect upon the principles and obligations of the Code of the Professional standards of conduct, ethics and performance for pharmacists in Northern Ireland, relating to personal and professional conduct in order to maintain the public's confidence in the profession.

Gary Potter

Chair of the Statutory Committee

08 September 2023