Section 29 Case Meeting

15 November 2022

157-197 Buckingham Palace Road, London SW1W 9SP

Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Mark Stobbs, Director of Scrutiny & Quality, Professional Standards Authority
Graham Mockler, Assistant Director of Scrutiny & Quality (Performance), Professional Standards Authority

In attendance
David Bradly, of Counsel, 39 Essex Chambers, Legal Advisor

Observers
Siobhan Carson, Senior Scrutiny Officer, Professional Standards Authority
Dami Olatuyi, Accreditation Officer, Professional Standards Authority
Imogen Peroni, HR & Governance Administrator, Professional Standards Authority
Alicia Hasperue, Scrutiny & Quality Data Administrator, Professional Standards Authority

1. Definitions

1.1 In this meeting note, standard abbreviations have been used. Definitions of the standard abbreviations used by the Authority, together with any abbreviations used specifically for this case are set out in the table at Annex A.

2. Purpose of this note

2.1 This meeting note records a summary of the Members' consideration of the relevant decision about the Registrant made by the regulator's panel, and the Authority's decision whether or not to refer the case to the court under Section 29 of the Act.

3. The Authority's powers of referral under Section 29 of the Act

3.1 The Authority may refer a case to the relevant court if it considers that a relevant decision (a finding, a penalty or both) is not sufficient for the protection of the public.

3.2 Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient:

- to protect the health, safety and well-being of the public

- to maintain public confidence in the profession concerned, and
- to maintain proper professional standards and conduct for members of that profession.

3.3 This will also involve consideration of whether the panel's decision was one that a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could not reasonably have reached; or was otherwise manifestly inappropriate having regard to the safety of the public and the reputation of the profession (applying *Ruscillo*[1]).

4. Conflicts of interest

4.1 The Members did not have any conflicts of interest.

5. Jurisdiction

5.1 The Legal Advisor confirmed that the Authority had jurisdiction to consider the case under Section 29 of the Act. Any referral in this case would be to the High Court of Justice of England and Wales and the statutory time limit for an appeal would expire on 23 November 2022.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 29 September 2022.

6.2 The Panel's Determination which includes the charges and findings is set out at Annex B.

7. Documents before the meeting

7.1 The following documents were available to the Members:

- Determination of the panel dated [redacted]
- The Authority's Detailed Case Review
- Transcripts of the hearing dated [redacted]
- Counsel's Note dated 13th November 2022
- Regulator's Bundle, Registrant's Bundles, Investigating Committee Bundle
- Registrant and GPhC Skeleton Arguments
- The GPhC's Good Decision Making Guidance
- The Authority's Section 29 Case Meeting Manual

[1] CRHP v Ruscillo [2004] EWCA Civ 1356

7.2 The Members and the Legal Advisor were provided with a copy of a response from the GPhC to the Authority's Notification of s.29 Meeting.

8. Background

8.1 The Registrant was employed by and worked within the Principal Pharmacists' team from 2017 as a Clinical Pharmacist. Within this role, he was responsible for screening prescriptions issued by General Practitioner Group. Concerns initially arose about the Registrant's clinical practice following the death of a patient in custody in January 2019. It was established from a Root Cause Analysis that the screening carried out by the Registrant was not robust. He had not picked up on interactions between drugs that should not have been prescribed together. No charge relating to this was before the panel.

8.2 The Registrant underwent regular supervision sessions with the Principal Pharmacist from February 2019. He made persistent errors and any improvements he made in his clinical practice were not sustained. As a result, Human Resources engaged in a capability process in December 2019. This process revealed six errors which form the basis for the six charges before the panel. Ultimately the capability process was escalated, written warnings issued and finally the Registrant was dismissed in August 2020. A number of other errors were identified during the process, but these did not form part of the charges against the Registrant. A referral was made to the GPhC and allegations of misconduct and/or deficient professional performance were referred for hearing.

8.3 The Registrant attended the hearing with representation before a GPhC Fitness to Practise Committee and admitted the charges in their entirety. The panel found that misconduct was made out but not deficient professional performance because the panel concluded that the six incidents did not represent a fair sample of the Registrant's work. The panel went on to find that the Registrant's fitness to practise is not impaired on public protection grounds, having found the risk of repetition to be low, and given his good insight and full remediation during the two years since the incidents. The panel considered these factors also meant a finding of impairment was not required in the public interest. The panel declined to impose a warning.

9. Applying Section 29 of the 2002 Act

9.1 The Members considered all the documents before them and received legal advice.

9.2 The Members discussed the following concerns about the decision:

Under-prosecution

9.3 The Members firstly considered whether the GPhC was in possession of material which ought to have caused it to make further charges in respect of additional clinical errors made by the Registrant. They discussed whether including additional failures in the Allegation was likely to have resulted in a finding of deficient professional performance and more serious misconduct, and

whether this is likely to have resulted in a different outcome in terms of the Registrant's fitness to practise and sanction.

9.4 However, the Members considered that the other information available to the GPhC was similar to that which formed the basis of the charges, and that the six charges were representative of the serious errors the Registrant had made. They considered that although the errors indicated a pattern of poor practice, they would not have been sufficient to alter the panel's view that the examples before them were not a fair sample of the Registrant's work: the Registrant screened over 3,000 prescriptions.

9.5 Further, having noted that the additional failings had been judged to be less serious than the incidents charged, that the Registrant had not been responsible for the death of the patient, and that the committee was aware of the other incidents, the Members did not consider that, had there been additional charges, it would have made a difference to the panel's assessment of the seriousness of the misconduct, and ultimate decision on impairment.

9.6 The Members could not therefore conclude that there had been a serious procedural error by the GPhC in not including the further errors as additional charges.

The impairment finding

9.7 The Members next discussed whether the panel's decision to find the Registrant's fitness to practise not impaired on public protection or public interest grounds, and consequent lack of sanction, was wrong.

9.8 The Members considered that the reasons the Panel provided in relation to public interest impairment failed to explain why a finding of impairment was not required in response to serious and repeated errors being made despite action being taken by the Registrant's employer. Given the finding of no impairment, and that no warning was imposed, the Members noted that the decision will not be published and no record made on the register. They therefore considered it highly unlikely the public hearing itself has maintained public confidence or declared professional standards.

9.9 However, the Members noted the finding of misconduct the panel had made, and that it had described the conduct as serious. They bore in mind that a finding of misconduct does not necessarily lead to a finding of impairment and that deference is due to the panel. The Members considered it was highly relevant that there had been no repetitions of any misconduct in the two years or so which have elapsed since his dismissal, and neither had there been any previous incidents. They considered the Registrant's conduct to be remediable, and that he had taken significant steps to remedy his failings.

9.10 Bearing this in mind, together with the insight and reflection he has shown, and the evidence about his current practice as a pharmacist (in respect of which the panel found that he is making a positive contribution to the profession), the Members agreed with the conclusion that the Registrant does not present an actual or potential risk to patients.

9.11 In addition, the Members did not consider it could be said that the Registrant might bring the profession into disrepute now or in the future. They considered it

relevant that his misconduct has been admitted and aired at a public hearing and concluded that a well-informed member of the public would likely not consider a finding of impairment necessary to either declare and uphold standards or to maintain public confidence in the profession. Therefore, although the Members considered the Panel's reasoning on public interest impairment to be perfunctory, they could not conclude that a finding of impairment on public interest grounds was required. The Members agreed that, on balance, it was open to the panel to reach the finding that it did, and therefore this was not a decision that no reasonable panel could have reached.

Failure to issue a warning

9.12 Next, the Members considered whether, having found the Registrant's fitness to practise not impaired, the Panel should have given a warning to the Registrant, and whether there are any consequences from it not doing so.

9.13 The Members considered the Panel's decision not to impose a warning was extremely brief and that it did not make any reference to the sanctions guidance. They noted that the guidance – 'Good Decision Making' does, however, provided the following about when a warning may apply:

> *''There is a need to demonstrate to a registrant, and more widely to the profession and the public, that the conduct or behaviour fell below acceptable standards. There is no need to take action to restrict a registrant's right to practise, there is no continuing risk to patients or the public and when there needs to be a public acknowledgement that the conduct was unacceptable.''*

9.14 The Members considered that, given the seriousness of the failings, this appeared to be precisely the sort of case where a warning should have been issued to mark the public interest, despite the fact that clinical failings have now been remedied. They considered that the Panel appeared to have failed to take into account that a warning would be visible on the register, whereas having found no impairment, the decision would not be in the public domain.

9.15 However, despite these concerns, and the poor reasoning of the Panel, the Members could not be sure that the Panel's decision was completely wrong, given the Registrant's remediation and lack of attitudinal concerns. The Members concluded that a warning would, in their view, have been more appropriate. However, they could not conclude that it was a decision that no reasonable panel could have reached.

Conclusion on insufficiency for public protection

9.16 The Members were concerned about the panel's lack of reasoning on public interest impairment and the decision not to issue a warning. Nevertheless, for the reasons set out above, they concluded that the decision was not manifestly inappropriate. In all the circumstances, therefore, it was not insufficient for public protection.

10. Referral to court

10.1 Having concluded that the panel's Determination was not insufficient for public protection, the Members were not required to consider whether they should exercise the Authority's power under Section 29 to refer the case to the relevant court.

11. Learning points

11.1 The Members agreed that the learning points set out at Appendix C should be communicated to the Regulator.

25/11/22

Alan Clamp (Chair) **Dated**

12. Annex A – Definitions

12.1 In this note the following definitions and abbreviations will apply:

The Authority	The Professional Standards Authority for Health and Social Care
The Panel	A Fitness to Practise Committee of the GPhC
The Registrant	
The Regulator	The General Pharmaceutical Council
Regulator's abbreviation	GPhC
The Act	The National Health Service Reform and Health Care Professions Act 2002 as amended
The Members	The Authority as constituted for this Section 29 case meeting
The Determination	The Determination of the Panel sitting on 2022
The Court	The High Court of Justice of England and Wales