Virtual Section 29 Case Meeting

16 March 2022

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

Asif Hamid Bhatti

Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Mark Stobbs, Director of Scrutiny & Quality, Professional Standards Authority
Seun Fagbohun, Administrator, Professional Standards Authority

In attendance
Nicola Greaney, barrister, 39 Essex Chambers, Legal Advisor

Observer
Siobhan Carson, Scrutiny Officer, 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(2)(a) of the Act. Any referral in this case would be to the High Court of England and Wales and the statutory time limit for an appeal would expire on 22 March 2022.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 25 January 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 25 January 2022
- The Authority's Detailed Case Review
- Transcripts of the hearing on 25 January 2022
- Counsel's note
- Regulator's bundle
- Registrant's bundle
- Investigation Committee's bundle and decision
- Skeleton Argument on behalf of the GPhC
- GPhC's sanctions 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, which the Members read and considered after they had reached their decision on whether the GPhC's decision was insufficient to protect the public.

8. Background

8.1 The Registrant had been employed as a locum Pharmacist with Boots UK Limited (Boots) at the Strand, London and involved the Registrant falsifying the initials of colleagues on prescriptions that he had self-checked. The system in place at Boots required the use of a 'Quad Stamp', confirming the completion of accuracy, dispensing, clinical and handout checks before a prescription could be dispensed to a member of the public.

8.2 The concerns came to light when a fellow-pharmacist noticed that that the accuracy check box for a Methadone prescription had been signed with the initials of Person A, a dispenser at the Pharmacy. Following enquiries, Person A confirmed that she was not on duty at the time, confirming that she had started work on 12:30 pm and that her initials had been entered prior to her arrival on the day in question.

8.3 When asked, the Registrant denied any wrongdoing and suggested that one of the two other dispensers must have signed the prescription. Person B had confirmed that she was not on duty at the time when the methadone prescription was stated to have been checked. When CCTV images were reviewed it was noted that the only two members of staff on duty were the Registrant and Witness C, a Pharmacy Technician who was on the other side of the Pharmacy and therefore the conclusion was reached that it was the Registrant who had falsified the signature.

8.4 Prior to these concerns coming to light, in September/October 2019, it had been noted that the Registrant had been self-checking and signing all four boxes on the Quad-Stamp when there were available staff members to complete the checks. The Boots Standard Operating Procedure required to be followed by Dispensary Team Members permitted accuracy checks on items assembled in the dispensary to be undertaken by a suitably trained Pharmacy Advisors and in circumstances that none were available, permitted the Pharmacist to carry out a final accuracy self-check once a 'mental break' had been taken to minimise the risk of error.

8.5 The Registrant was advised that incidents of self-checking needed to be reduced. Patient Safety Reviews were undertaken each month in order to achieve a reduction in self-checking however the Registrant's rate of self-checking largely continued unchanged.

8.6 On 24 June 2020 the Registrant had approached another locum Pharmacist to check a faxed prescription for a contraceptive tablet. The dispensing and clinical checkboxes had been signed by the Registrant. The other Pharmacist had not signed the accuracy box on the faxed prescription, pointing out that it had not

been labelled as 'emergency supply' and was therefore not valid. She noticed later that the accuracy check box had been signed with her signature in black pen. Her evidence was that she had not signed the prescription and further that she always used bright coloured pens and that the signature on the prescription was not hers.

8.7 At an investigatory meeting on 1 July 2020, the Registrant initially denied signing the Quad stamps on behalf of colleagues but subsequently admitted that he had been self-checking and falsifying colleagues' signatures. At a disciplinary meeting on 6 July 2020, he made full admissions to falsifying signatures and to signing dispensing checkboxes on behalf of other colleagues around 'once or twice a week'. He was summarily dismissed and referred to the GPhC.

8.8 In front of Panel, the Registrant admitted the allegations he faced. He gave oral evidence to the panel and provided evidence of reflection and remorse and references which indicated that he was well thought-of by his present employers. He indicated that he had taken the action because of the "toxic" atmosphere in the workplace.

8.9 The Panel agreed that the Registrant's actions amounted to misconduct. It noted, however, that the simple action of self-checking was not prohibited by the GPhC's guidance and had been the approved practice in the Registrant's previous workplace. Of itself, the self-checking might not have amounted to misconduct. However, the dishonesty and the impact on colleagues was serious.

8.10 Having heard his evidence, the Panel decided that the Registrant had reflected and developed strategies which would ensure that the misconduct and dishonesty would not be repeated. He was, therefore, not impaired on public protection grounds. The Panel decided that in the circumstances set out in the decision, there was no need for it to find impairment on grounds of upholding professional standards or maintaining public confidence. It decided not to impose a Warning either.

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:

The decision on public protection

9.3 The Members considered that the Panel's decision that the Registrant was not impaired on public protection grounds had been open to it. The reflective statements contained apologies and reflections and the Panel had explored how the Registrant would deal with similar stresses in the future and why the Registrant had continued to self-check even after he had been told to reduce the practice. While there was little evidence to support the suggestion that

there was a "toxic" environment in the workplace, the Members considered that the Panel's decision was open to it and that the courts would be likely to defer to it. They therefore had no concerns about this aspect of the decision.

The decision on public interest impairment

9.4 The Members noted that the Panel's decision on the public interest aspects of impairment was extremely brief, saying simply that:

> *We have taken into account the wider public interest criteria and the comments in the Grant case referred to above. Taking into account the full circumstances of this case, the Registrant's remorse, insight and remediation, we do not consider that fully informed members of the public would demand a finding of current impairment.* (Paragraph 53)

9.5 The Members were concerned that the Panel appeared simply to concentrate on the reasons why there was no impairment on public protection grounds and had not considered matters which were relevant to upholding standards and the public interest. These included:

- The dishonesty, which the sanctions guidance makes clear should, except in exceptional circumstances be treated as being seriously. The Members could see no exceptional circumstances in this case and noted that, while the Panel may have considered that the dishonesty had been remediated, this was of less weight in respect of public interest impairment.
- The dishonesty had, moreover, been repeated frequently over a number months.
- The dishonesty involved forging the signatures of colleagues who could have found themselves subject to criticism had there been an error.
- While the employer's approach was not mandated by the GPhC and there was no evidence of patient harm, there were good patient safety reasons for it and the Registrant's failure to follow its processes, despite being reminded to do so added to the seriousness of the case.

9.6 The Members could see no evidence that the Panel had considered these matters or how it had weighed them against the remediation to which it did refer.

Conclusion on insufficiency for public protection

9.7 The Members concluded that the Panel had failed to consider the very serious aspects of the case in considering whether the Registrant was impaired on public interest grounds. The Members considered that the matters set out at paragraph 9.4 above were inherently serious and were likely to point either to impairment or, at the very least, a warning. In the Members' view, the Panel had given too much weight to the Registrant's remediation and had failed to have appropriate regard to the GPhC's sanctions guidance or to explain why, given the seriousness of the conduct, impairment was not required to uphold professional standards or maintain public confidence. The Members considered the Panel's decision in this respect was wrong and insufficient to protect the public.

10. Referral to court

10.1 Having concluded that the panel's Determination was insufficient to protect the public on the grounds that it was not sufficient to uphold professional standards or maintain public confidence, the Members considered whether they should exercise the Authority's discretion to refer this case to the relevant court.

10.2 In considering the exercise of the Authority's discretion, the Members received legal advice as to the prospects of success and took into account the need to use the Authority's resources proportionately and in the public interest. They also took into account comments by the GPhC.

10.3 Taking into account these considerations, along with advice on the prospects of success, the Members agreed that the Authority should exercise its power under Section 29 and refer this case to the High Court in England and Wales.

18/3/22

Alan Clamp (Chair) **Dated**

11. Annex A – Definitions

In this note the following definitions and abbreviations will apply:

The Authority	The Professional Standards Authority for Health and Social Care
The Panel	The Fitness to Practise Committee of the GPhC
The Registrant	Mr Asif Hamid Bhatti
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 25 January 2022
The Court	The High Court of Justice of England and Wales