THE ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN

Disciplinary Committee

Tuesday, 6 April 2010

Chairman - MS SIOBHAN GOODRICH

Committee Members:

Mrs Judith Way
Mr. Peter Jones

Case of:

ROSSIER, Achmat (64732)

MR. A. ROSSIER was present but was not represented.

MR. S. WIKLUND, Senior Case Manager, appeared on behalf of the Society.

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DETERMINATION OF THE COMMITTEE (Facts)

The committee is concerned with the first stage of disciplinary proceedings in relation to allegations made against Mr. Rossier, a pharmacist who first registered with the Society on 25 June 1971. At all material times Mr. Rossier was a superintendent pharmacist and director of the Milton Road Pharmacy in Cambridge. The allegations against Mr. Rossier are a matter of record. They fall into two parts which relate to different alleged events in 2006 and 2008. We have considered our findings of fact in relation to allegations made separately.

The first set of allegations relate to Mr. Rossier's supply of a controlled drug to a Mr. Peckham in June 2006. The agreed background facts are that on 26 June 2006, the Milton Road Pharmacy supplied to Mr. Peckham 100 milligrams Morphine Sulphate tablets, two to be taken twice daily, against a prescription calling for 10 milligrams Morphine Sulphate tablets, two to be taken twice daily. Mr. Rossier was on duty and was responsible for the supply against the prescription. This was to be provided by way of a dossette box delivered to the patient. The dossette box was assembled by dispensing assistant Mrs Natasha Heeps, and was thereafter delivered to the patient. It is not disputed that Mr. Peckham was provided with Morphine Sulphate tablets at ten times the strength prescribed by the doctor. On 26 June 2006 Mr. Peckham died at Addenbrookes Hospital.

The death was investigated by the police who conducted interviews under caution with those present in the pharmacy on 22 June 2006: Mr. Rossier, Mrs Natasha Heeps and Mrs Rossier. At the interview on 12 July 2006, Mr. Rossier provided the police with a standard operating procedure concerning the assembly of dossette boxes at the Milton Road Pharmacy.

An inquest into the death of Mr. Peckham was held on 6 and 7 May 2008 and the decision and verdict was handed down on 19 June 2008. It was concluded by Her Majesty's coroner (who I shall refer to hereafter as 'the Coroner') that "Mr. Peckham, suffering from terminal cancer, received from the nominated pharmacy, and ingested,

Morphine Sulphate ten times stronger than that prescribed by his general practitioner, and died from the effects of that overdose".

The Coroner's decision called into question Mr. Rossier's conduct. The Coroner also considered that Mr. Rossier had demonstrated an inclination to place responsibility for Mr. Peckham receiving an incorrectly made up dossette box firmly at the door of Mrs Heeps. He considered this to be "entirely unacceptable, reprehensible and a **prima facie** breach of his professional obligations and the duty of care to Mr. Peckham". The Coroner recorded his concern as to whether the standard operating procedure that had been produced by Mr. Rossier to the police in interview was in existence at the time of the incident, but he made no express finding on this. In other respects, he stated that, in so far there was a difference between them, he preferred the account of Mrs Heeps to that Mr. Rossier. He expressed his concern as to the systems in operation at the Milton Road Pharmacy.

Mr. Rossier admitted at the outset of these proceedings the following particulars, which I will read:

"That being registered with the Society on 25 June 1971:

(1) Mr. Achmat Rossier, while practising as a superintendent pharmacist at Milton Road Pharmacy, 123 Milton Road, Cambridge CB4 1 XE:

(a) supplied prescription only medicines otherwise than in accordance with the prescription contrary to section 52(2)(a) of the Medicines Act 1968;

(b) supplied a medicinal product not of the nature specified in the prescription contrary to section 64(1) of the Medicines Act 1968".

The relevant particulars in relation to those two admitted matters were also admitted by Mr. Rossier as follows:

"(i) on 26 June 2006 Mr. Rossier supplied to Mr. Anthony Peckham 100 milligrams Morphine Sulphate tablets, two to be taken twice daily, against a prescription calling for 10 milligrams Morphine Sulphate tablets, two to be taken twice daily, and--

(ii) on 26 June 2006 Mr. Anthony Peckham died at Addenbrookes Hospital due to a morphine overdose".

We find those facts proved on Mr. Rossier's admission. I should also say that Mr. Rossier also accepted and admitted that, following an inquest into Mr. Peckham's death by Her Majesty's Coroner heard on 6 and 7 May 2008, the decision and verdict handed down on 19 June 2008 called into question his conduct, and that appeared at (iii) of the particulars of the allegation.

Mr. Rossier was unable to admit sub-paragraph (4), which reads as follows:

"In the decision and verdict, Her Majesty's Coroner also described Mr. Rossier's inclination to place responsibility for Mr. Peckham receiving an incorrectly made up dossette box firmly at the door of Mrs Heeps as entirely unacceptable, reprehensible and a **prima facie** breach of his professional obligations and duty of care to Mr. Peckham".

Mr. Rossier also disputed breaches alleged at paragraphs (c) and (d) of the particulars of allegation, which I will read in full:

"(c) failed to act in the best interests of patients and other members of the public and seek to provide the best possible health care for the community in partnership with other health professions, contrary to Key Responsibility 1 of the Code of Ethics and Standards;

(d) failed to ensure that he behaved with integrity and probity, adhered to accepted standards of personal and professional conduct, and engaged in behaviour or activity likely to bring the profession into disrepute or undermine public confidence in the profession, contrary to Key Responsibility 3 of the Code of Ethics and Standards".

The essence of the Society's case was that Mr. Rossier had made a series of errors that led to the incorrect supply of Morphine Sulphate being made to Mr. Peckham, and this was contrary to his obligations under Key Responsibility 1 of the Code of Ethics and Standards. The facts of this case also involved a systematic failure on the part of Mr. Rossier, a superintendent pharmacist, to ensure that proper systems were in place to protect patient' safety. In particular, it was the Society's case that the standard operating procedure, which Mr. Rossier had produced to the police when interviewed on 12 July 2006, if it was in place at all, was insufficient. Other members of staff involved had given far extensive explanations as to the correct procedures to be followed in respect of dossette boxes which tended to suggest that they had been following regular procedures rather than any written standard operating procedure. The answers in the police interview by Mr. Rossier suggested that he had written the document in question the week before the interview. Further, it was the Society's case that, in the Coroner's inquest, Mr. Rossier had appeared to suggest that Mrs Heeps was to blame for what had happened. This was not in accordance with his professional obligations under Key Responsibility 3, and had led to his conduct being called into question by the Coroner.

The essence of Mr. Rossier's case was as follows. He had always accepted that the supply of ten times the strength of Morphine Sulphate intended by the prescriber to Mr. Peckham was his responsibility, because he was the pharmacist. He considered that the comments of the Coroner were harsh and unfair. He found it difficult to understand how the coroner had preferred the evidence of Mrs Heeps to that given by himself and his wife. At the Coroner's inquest he had explained the system as to how the dossette box should have been assembled by Mrs Heeps. He could not understand what had gone wrong so as to lead Mrs Heeps to place the wrong strength of tablets in the dossette box. He considered that there had been a break in the cycle of communication and trust, and it was this that led to the incorrect strength of Morphine Sulphate being supplied to Mr. Peckham.

Mr. Rossier told us that he had learned that Mrs Heeps had visited the Mr. Peckham family after the death. He believed that in some way this had fuelled the criticism of the lawyer representing the family, and that this in turn had infected the reasoning of the

Coroner. He felt that his efforts to answer the detailed questions asked of him had been misinterpreted because the Coroner "did not like him". He plainly still feels a strong sense of injustice.

In his evidence before us Mr. Rossier said that he considered that the Coroner did not pay sufficient attention to the fact that Mrs Heeps had withdrawn a controlled drug from the controlled drugs cabinet on this occasion without asking his permission. She had always requested permission when she had removed schedule 3 controlled drugs previously. His evidence was that he had directly supervised the removal of any controlled drugs from the controlled drugs cabinet, either by opening the cabinet himself or by watching Mrs Heeps do so. This was the first time that she had had occasion to dispense a schedule 2 controlled drug.

Mr. Rossier could not understand how anyone could base any views as to what had happened on the evidence of Mrs Heeps. He felt that in some way Mrs Heeps was motivated against him because the Home Office had rejected her application for a work permit. Mrs Heeps had left his employment very shortly after the events concerning Mr. Peckham. In July 2006, and subsequently, he had made telephone inquiries of her former employers in South Africa so as to find out more about her background. He felt that he just had to find out "what it is with this person to have done what she did". He disputed the accuracy of Mrs Heeps' description of what it was like to work in the Milton Road pharmacy.

The basic facts in this case are not in issue. We consider that sub-paragraph (4) of the particulars of allegation accurately reflects the Coroner's position and views. It cannot be gainsaid that the Coroner expressed his own view as to the effect of Mr. Rossier's evidence, which he considered was a "**prima facie**" breach of his professional obligations. This is what lies at the heart of the disputed allegation at paragraph 1(d). It is common ground that whether or not Mr. Rossier's attitude in the Coroner's inquest did or did not amount to a breach of his professional obligations is a matter for this panel to determine.

In considering all of evidence in this case, we reminded ourselves throughout that the

Society bears the burden of establishing the allegations made. Mr. Rossier was not required to prove anything. The burden can only be discharged by the Society if, on the evidence before us, we are satisfied to the appropriate standard that Mr. Rossier acted in the manner alleged against him.

The standard of proof in these proceedings is the civil standard, i.e. the balance of probabilities. We were at all times mindful of the guidance provided by the House of Lords in Re B [2008] UKHL 33 and in Re D [2008] UKHL 35, and have considered very carefully whether the standard of proof has been met by the Society in this case.

We should say that our consideration of this case has not been assisted by the fact that the transcript of the inquest is incomplete. Initially a transcript of the first day only was provided by the Coroner's office. This in itself was incomplete because most of the answers were inaudible. Representations by the Society to the Coroner's office resulted in the production of a recording of both days. It was directed in these proceedings that the Society should use its best endeavours to provide the best transcription possible.

The full transcript did include the statement of the witnesses which had been read into the record at the inquest. However, most answers by the witnesses who gave evidence remained recorded as inaudible, which tends to suggest that the problem was with the witness microphone. In these circumstances, we were extremely cautious when reading the transcript.

We also bore in mind throughout our consideration of the facts, the nature and remit of a coronial process. We were mindful that particular pressures may be operative in such proceedings where there is at least the possibility that a verdict of unlawful killing may be returned. We bore all this in mind and considered whether Mr. Rossier may have been unable to do justice to his position in a process that was essentially inquisitorial, and where he may have been under some considerable stress.

We decided that the fairest way to decide the disputed matters would be to consider the nature and quality of Mr. Rossier's evidence before us, because that may illuminate the issue of his attitude to his professional responsibilities before the Coroner. Whilst we

considered the transcript, we bore in mind that we had not had the opportunity to see that evidence being tested, and we should therefore exercise caution before acting on such evidence where it was not agreed. We bore in mind that less weight may be given to statements, albeit on sworn testimony, in other proceedings that have not been tested in evidence before us. We bore in mind also the difficulties that any professional may face in doing justice to his position in a Coroner's inquiry, given the nature of such proceedings.

As the nature of the Society's case called into question Mr. Rossier' integrity and probity, we considered the issue of his character. The Society agreed that we should receive character evidence at the fact finding stage. We have carefully considered the oral evidence of Mr. Mir, and the statements of Mr. Uddin, Dr. Fertig and Dr. Hughes. Good character of itself cannot provide a defence to the allegations made. However, the fact of Mr. Rossier's good character is capable of supporting his credibility generally, and we decided that we should take this into account when deciding whether the Society had discharged the burden of proof upon it.

We heard evidence from the Society Inspector Mr. Ibbitt, who had visited Mr. Rossier before and after the events of June 2006. The committee considered that Mr. Ibbitt was conspicuously fair in his evidence. He told us that he had been present throughout the Inquest. In a considered and measured response he told us that his impression was that Mr. Rossier "started off by saying he was responsible, and then described what happened in ways that suggested that other people's actions were responsible".

We considered very carefully whether the manner in which Mr. Rossier had sought to explain the stages of the dispensing process at the inquest had been misinterpreted as an abdication of his overall responsibility. We have considered Mr. Rossier's evidence before us very carefully and formed our own view as to the circumstances surrounding the admitted facts and his past attitude to his professional responsibilities. We consider that although Mr. Rossier accepted "legal responsibility" for all the events that occurred, because he was in charge "as captain of the ship", his real attitude was (and remains) that he had been let down by Mrs Heeps who had failed to follow the instructions that he had given her. Although he sought to control this attitude, it permeated his evidence before us.

The signal fact is that the first mistake that set in train the events that unfolded was Mr. Rossier's own and admitted error. When seeking to perform his own professional task, Mr. Rossier accidentally selected the wrong strength of Morphine Sulphate on the dropdown menu on the computer programme. This then resulted in the production of the backing sheet which was incorrect, and that it referred to 100 milligrams Morphine Sulphate. We accept that such mistakes can be made. It is for this very reason that professional standards require that additional checks are in place and are performed. In accordance with standard practice, it was Mr. Rossier's professional duty to check the backing sheet against the prescription to ensure that he had not made an error. He failed to do so.

The dossette box was thereafter assembled by Mrs Heeps on the basis of that erroneous backing sheet. We noted that Mrs Heeps openly acknowledged in her account to Mr. Rossier, to the police and in her evidence to the Coroner, that she knew that she should have checked the backing sheet against the prescription during this process, but said she did not do so because she had been distracted.

The final check before supply occurred was the sole responsibility of Mr. Rossier as pharmacist. He told the police and the Coroner that he had failed to check that the assembled dossette box was in accordance with the prescription because he was busy.

On the facts, we find that the wrongful supply started and ended with Mr. Rossier's own failures to supply the prescribed drug in accordance with the law and professional standards. In these circumstances, it is difficult for us to understand why Mr. Rossier has persisted in seeking to understand (to paraphrase his own words) why Mrs Heeps made the mistake that she made. In our view, what Mrs Heeps did was but a small part in the chain that led to the patient receiving the overdose. The fact that Mr. Rossier has persisted as seeing the actions of Mrs Heeps as the most important factor in all that happened leads us to conclude that this was indeed the inclination that he had demonstrated in his evidence at the inquest.

Having heard a considerable amount of evidence concerning the systems in operation

at the material time, we should make clear our views. As we have already indicated, Mr. Rossier sought to rely upon a document concerning dossette box assembly that he produced to police when interviewed on 12 July 2006. In contrast to the other standard operating procedures which were signed and dated by Mrs Heeps, this had not been signed by her to acknowledge that she had seen and read it. As indicated above, the Society placed reliance on an answer in the police interview from which it might be inferred that Mr. Rossier had said that he had prepared this document shortly before the interview on 12 July 2006. We should say that we place no reliance on this part of the interview because the whole sequence of questions and answers, read together, could be taken to suggest that Mr. Rossier was referring to a different standard operating procedure.

In evidence before us, Mr. Rossier's position was that the document was available to Mrs Heeps in a file on the shelf in the back room, but he was unable to confirm that he had brought it to her attention. His position was that it was nonetheless available to Mrs Heeps, although in other answers he gave indicated that he himself had difficulty in finding the standard operating procedures when needed.

It is unnecessary for us to make any finding as to whether or not the document existed before June 2006. The document for dossette box assembly that Mr. Rossier had given to the police did not cover the inclusion of controlled drugs in a dossette box. Mr. Rossier's evidence in this regard was to the effect that he had relied on the fact that he had personally trained Mrs Heeps in relation to weekly dossette box dispensing, and had no reason to think that she did not understand her task. In our view, whether it was in existence before 22 June 2006 or not, the document was inadequate as a standard operating procedure for the assembly of controlled drugs in a dossette box in any event.

On the evidence before us, we do not consider it likely that Mr. Rossier had always supervised the withdrawal of controlled drugs from the controlled drugs cabinet on all occasions. We consider it unlikely that Mrs Heeps would have chosen to gain access to the controlled drugs cabinet on this occasion unless she had been permitted to do so previously, either expressly or by implication.

Further, the manner in which the key to the controlled drugs cabinet was kept in an unlocked drawer at the Milton Road Pharmacy was inadequate to ensure that the cabinet was not opened and controlled drugs withdrawn unless under the supervision of a pharmacist. We find that no actual supervision of Mrs Heeps was provided by Mr. Rossier when she dispensed Morphine Sulphate for Mr. Peckham.

In all these circumstances, it is difficult to understand why Mr. Rossier, as a superintendent pharmacist and as a supplying pharmacist on this occasion, sought to place his own errors in the context that he had been let down by his dispensing assistant. As we have already stated, Mr. Rossier himself made the first error. Had he followed standard professional practice and compared the backing sheet to the prescription, he would have realised his mistake before the backing sheet was provided to Mrs Heeps to dispense. If the system at the pharmacy had not been so lax as to allow a dispensing assistant to obtain the controlled drugs from the controlled drugs cabinet without being directly supervised by the pharmacist, the early errors would have been noticed. Further, had Mr. Rossier met his professional obligation and checked the backing sheet against the prescription after the dossette box had been made up, the wrong supply would not have been made. Finally, the assembled dossette box was not checked by Mr. Rossier. This final check is a standard professional obligation and yet was not performed at all. On his own evidence, Mr. Rossier knew that Mrs Heeps had never dispensed Morphine Sulphate before, so the need to carefully check her work on this occasion was paramount.

Having seen and heard Mr. Rossier give evidence, we are satisfied on the balance of probabilities that in the Inquest he was inclined to place responsibility for what happened firmly at the door of Mrs Heeps. Indeed we consider that his true attitude was (and remains) that Mrs Heeps should have prevented the effect of his own errors. Despite what he said about his recognition of his legal responsibility, his suppressed irritation that she did not do so was quite apparent in his evidence before us.

For all the reasons given above, we find that the allegation at 1(c) that Mr. Rossier failed to act in the best interests of patients and other members of the public, and seek to provide the best possible health care for the community in partnership with other health

professions in breach of Key Responsibility 1 of the Code of Ethics and Standards, has been proved on the balance of probabilities by the Society.

Further, the Society has satisfied us to the same standard that Mr. Rossier failed to ensure that he behaved with integrity and probity, adhered to accepted standards of personal and professional conduct, and engaged in behaviour or activity likely to bring the profession into disrepute, or undermine public confidence in the profession, contrary to Key Responsibility 3 of Code of Ethics and Standards. We find the allegation at 1(d) proved.

The second set of allegations relates to the supply of prescription only medicine otherwise than in accordance with the prescription contrary to section 58(2)(a) of the Medicines Act 1968. Mr. Rossier admitted at the outset of this hearing that on 1 or 2 July 2008 he supplied to a patient NN Chlordiazepoxide 10 milligrams with directions three to be taken 4 times a day for the first week, then three, 3 times a day for the second week, whereas in fact the prescription called for Chlordiazepoxide 10 milligrams, 30 milligrams four times a day on 30 June 2008, and 30 milligrams three times a day on 1 July 2008. Although the facts in relation to second charge were admitted, it is appropriate to set out our findings in relation to the background circumstances.

Chlordiazepoxide is a drug that may be used in reducing doses for the purpose of alcohol detoxification. It was prescribed on this occasion for two specified days. The prescriber intended that the amount of the drug prescribed was to reduce on the second day. Whilst admitting the incorrect supply, Mr. Rossier suggested in his interview with the Society Inspector, Mrs Melvin, that the prescription was ambiguous. He produced a prescription before us which shows that prescriptions can be written so that the number of days supply is spelt out in words, whereas the prescription in question in this case referred to the actual dates. It is true that some prescribers may use a different method from that employed in this case, but either method is appropriate. We find that there was no ambiguity whatsoever in the prescription that Mr. Rossier dealt with in early July 2008. Quite apart from the fact that Mr. Rossier supplied this drug for two weeks rather than two days, he also made an error in relation to the reducing dosage.

Those are our reasons in relation to the facts that we have found.

DETERMINATION OF THE COMMITTEE (Impairment)

CHAIRMAN: We refer to the findings that we have already made. In our judgment the matters that we have found proven do amount to misconduct.
We have considered a number of authorities in relation to the assessment of fitness to practise in regulatory proceedings such as these, including the cases of Cohen v General Medical Council [2008] EWHC 581 (Admin), Zygmunt v General Medical Council [2008] EWHC 2643 (Admin), Azzam v General Medical Council [2008] EWHC 271 (Admin), and Cheatle v General Medical Council [2009] EWHC 645 (Admin).

Put simply, as it was in the case of the Cheatle, (and appropriately adapted) it can be stated thus:

"In coming to a conclusion on impairment, the authorities make clear that the panel must look forward. It must consider whether, in the light of what happened and of the evidence as to the (practitioner's) conduct and ability demonstrated before and after his misconduct, fitness to practise is impaired by the particular events".

The following passage, which appears in case of Zygmunt, is also of assistance and has guided us in our deliberations. At paragraph 31 of that judgment, Mitting J said:

"In a misconduct or deficient performance case the task of the panel is to determine whether fitness to practise is impaired by reason of misconduct or deficient performance. It may well be, especially in circumstances in which the practitioner does acknowledge his deficiencies and takes prompt and serious steps to remedy them, that there will be cases in which a practitioner is no longer any less fit to practice than colleagues with an unblemished record".

His Lordships continued:

"With one qualification I agree with and adopt the judgment of Silber J in Cohen v GMC [2008] EWHC 581 (Admin) at pages 62 to 64.

62. Any approach to the issue of whether a (practitioner's) fitness to practise should be regarded as 'impaired' must take into account 'the need to protect the individual patient and the collective need to maintain confidence in the profession as well as declaring and upholding proper standards of conduct and behaviour of the public in their doctors, and that public interest includes, amongst other things, the protection of patients, the maintenance of public confidence...' In my view, at stage 2 where fitness to practise is being considered, the task of the panel is to take account of the misconduct of the practitioner and then to consider, in the light of all the other relevant factors known to them, in answering whether by reason of the misconduct, his or her fitness to practise has been impaired.

63. I must stress that the fact that stage 2 is separate from stage 1 shows that it was not intended that every case of misconduct found at stage 1 must automatically mean that the practitioner's fitness to practise is impaired.

64. There must always be situations in which a panel can properly conclude that the act of misconduct was an isolated error on the part of a medical practitioner, and the chance of it being repeated in the future is so remote that his or her fitness to practise has not been impaired".

The qualification to which Mitting J referred related to the substitution of the present tense for the past tense in the second sentence of paragraph 62.

We refer to our findings in respect of the background circumstances and the allegations that we have found proven. In very brief summary, the facts concerning the supply of Morphine Sulphate to Mr. Peckham show that Mr. Rossier, as a supplying pharmacist on 22 June 2006, failed to act in accordance with basic standards of safe

practice. Moreover, the systems in place at the pharmacy, for which he was responsible as superintendent pharmacist, were inadequate to seek to guard against any pharmacist error that may occur, including his own, and those of his staff.

We have again considered all the evidence placed before us, including the evidence of Mr. Rossier as well as that of Mr. Mir, and other testimonial evidence in so far as it is relevant to the issue of current fitness to practise. We consider the issues we need to address are:

(a) is the misconduct remediable?

(b) has the misconduct been remedied?

(c) does Mr. Rossier's ability to practice represent a continuing risk to patients, i.e. is there a risk of a repetition?

We accept that the personal and systemic failures that occurred in June 2006 were always (and remain) capable of remedy. We have considered the evidence before us in relation to Mr. Rossier's response to the events that occurred in June 2006. Following the death of Mr. Peckham, one of the first things that Mr. Rossier did was to telephone South Africa in order to find out more about the character of Mrs Heeps from her former employers. Following the departure of Mrs Heeps from his employ, no other dispensing assistant was employed until late 2007, with the result that Mr. Rossier and his wife were working extremely hard and with virtually no holiday and very little time off.

Soon after the death of Mr. Peckham, Mr. Rossier was given clear advice in a letter dated 24 August 2006 by the Society's Inspector Mr. Ibbitt. Mr. Ibbitt had analysed the systems issues and made a number of recommendations specific to this pharmacy, as well as a suggested audit checklist. Mr. Rossier did not act on that advice at that stage. His evidence before us was to the effect that it was unnecessary to do so. A dispensing assistant was no longer employed, and he could 'trust' himself to complete the required tasks safely. In our view this showed a complete lack of insight into his own personal

failings and a degree of arrogance.

Despite the advice of Mr. Ibbitt, he did not take any steps to implement any systematic check in relation to his own actions as a pharmacist thereafter. It was quite clear from his evidence that he considered that there was no need to do so because he has as always seen the error as that of his dispensing assistant. Mr. Rossier told us of changes that have been made in or about 2008 at the Milton Road Pharmacy in relation to the assembly of dossette boxes, and we saw an example of this. This now has a check box proforma which is attached to the dossette box. We noted that he did invest in a new computer system. Although it is true to say that such changes represent some improvement, we took note of the fact that the changes still tend to concentrate upon the aspects of dossette box assembly.

We have considered the report of Mrs Melvin, the Society's Inspector, dated 11 June 2009. In short, three years after Mr. Peckham's death, there were still many matters concerning basic safety issues in relation to controlled drugs which required attention in the standard operating procedures. It was necessary for her to advise Mr. Rossier that the controlled drugs cabinet key should be kept on his person at all times, and that non-pharmacy staff should only have access with express permission on each occasion.

We noted that Mr. Rossier had not attended any courses at all. He has maintained no records in respect of his CPD.

We consider that Mr. Rossier has been and remains unable to accept his own responsibility for the events of June 2006. In our view it is quite clear that Mr. Rossier has learned little from the events of 2006. He still sees himself as a man betrayed by his dispensing assistant.

We turn to the events of 2008 when Mr. Rossier interpreted an unambiguous prescription in a way that resulted in a wrongful supply to a patient who had been prescribed medication as part of an alcohol rehabilitation programme. Mr. Rossier's case is that this second incident occurred because he was preoccupied and distressed by the criticisms of the Coroner - whose reasons had been provided to him in late June 2008.

We consider that Mr. Rossier's attitude to this matter was reminiscent of his response to the events of June 2006. He sought to suggest that he was not entirely responsible for the wrong supply having been made to a patient. He thought the prescriber had been at fault in the way he wrote the prescription. Mr. Rossier also considered that the prescribing doctor should have accepted his explanation when they spoke on the telephone, and moreover, that the medical practitioner's action in referring the matter to the Society was unfortunate, because there are often occasions when pharmacists have occasion to correct prescriber errors.

We consider that in both these respects the stance taken by Mr. Rossier is very regrettable. It tends to suggest that he believes that this was not a serious matter.

In our view Mr. Rossier has demonstrated in his evidence that he has no real insight into his professional responsibilities or the events that have led to his appearing before this committee. We have considered the issues of questions posed by Smith LJ in the fifth Shipman inquiry report. We consider that, in the light of the facts we have found and our view in relation to his lack of insight, Mr. Rossier' practice poses an unwarranted risk of harm to patients and is liable in the future to bring the profession into disrepute.

In the light of all the matters set out above, we conclude that Mr. Rossier's fitness to practise is impaired.

DETERMINATION OF THE COMMITTEE (Sanction)

CHAIRMAN: The committee has considered the issue of sanction in the light of our findings as to the circumstances that have brought Mr. Rossier before us, and our finding that his fitness to practise is impaired. The committee have again considered all of the material before it. We refer to the decisions we made in the earlier stages. We would simply emphasise the following points.

It is not the function of this committee to punish Mr. Rossier. Our function is to protect the public interest in the safety of patients, the maintenance of public confidence in the profession of pharmacy, and the declaration and maintenance of proper standards. We have considered all of the testimonial evidence from professional colleagues and patients who speak highly of Mr. Rossier's abilities. We know that Mr. Rossier is considered to be a good and conscientious practitioner by patients and local doctors who have used his services for many years. He has been a pharmacist for nearly 40 years and, in that time, has never had occasion to appear before this committee or its predecessor.

The events that occurred in 2006 concerning Mr. Peckham were plainly very serious. As soon as the error was discovered immediate steps were made to retrieve the dossette box from Mr. Peckham, but unfortunately some tablets had already been consumed.

There were multiple personal and systemic failures that led to the supply of ten times the strength of the dose of Morphine Sulphate intended, and this resulted in the death of a terminally ill patient.

We have borne in mind that Mr. Rossier, having qualified in 1971, may well have been slower to respond to the changing demands of current practice as heralded by the mandatory requirements in respect of standard operating procedures introduced in 2005, but the death of a patient should have prompted him to act swiftly thereafter. We have already stated our view that Mr. Rossier's response to events in 2006 showed a lack of insight even in relation to basic steps that should have been taken to seek to prevent the risk of another dispensing error. He failed to act on the advice of Mr. Ibbitt in a timely manner.

Whilst it is true that he took some measures in 2008, it is plain that, even as at June 2009, many matters directly relevant to the events that had occurred had still not been fully addressed. The fact is that, within just under two years, another incident had occurred which was essentially due to Mr. Rossier' misreading of a prescription. We have borne in mind that Mr. Rossier was preoccupied and upset at this time.

We do accept that Mr. Rossier has expressed his deep sorrow for the events that occurred. We have taken into account the loss of his reputation. We are well aware that any action affecting his registration will affect his reputation, his standing in the community and his ability to practice in the profession and for the community that he has served for 40 years.

We considered all of the sanctions available in ascending order and have borne in mind that any sanction imposed must be proportionate to the perceived risk to patient safety and the public interest, and must also balance Mr. Rossier's interests. In this case we considered that Mr. Rossier's continued practice poses a real and continuing risk to patients safety. Given the serious nature of our findings, a warning would be wholly insufficient to protect the public interest. We do not consider that any conditions could be imposed that would protect the public interest in this case, because Mr. Rossier has insufficient insight into the nature and seriousness of the shortcomings in his *personal*

performance as a pharmacist. A period of suspension would do nothing to address the underlying issues, including Mr. Rossier's lack of insight.

Notwithstanding the effects upon Mr. Rossier, we have concluded that Mr. Rossier's lack of insight and the continuing risk to patient safety is such that public confidence in the profession requires that his name be erased from the Register.

We should say that pursuant to Article 54(11) of the order, we revoke the interim suspension order made on 28 August 2008. That of course relates to the interim suspension order.

DETERMINATION OF THE COMMITTEE (interim measures)

CHAIRMAN: The committee have considered that matter and, in the light of its findings in relation to the risk to patient safety and the public interest, the committee is satisfied that it is necessary for the protection of members of the public, or is otherwise in the public interest, that Mr. Rossier's registration be suspended forthwith as an interim measure pending the coming into force of the direction; that of course relates to the possibilities of any pending appeal. That order is made pursuant to Article 58.