

Report of the Professional Conduct Committee (“the PCC or the Committee”) to the Council of the Pharmaceutical Society of Ireland in relation to a complaint made pursuant to Part 6 of the Pharmacy Act 2007 (“the Act”).

Introduction - Summary Details

Registered pharmacist:	Mr. Barinedum Serekara Yorkuri MPSI
Pharmacist Registration Number:	12563
Complaint Reference(s):	624.2021
Date of Inquiry:	16 April 2026
Public/Private Hearing:	Public
Meeting Format:	PSI House, Fenian Street, D2
Members of Committee:	Ms. Susan Ahern S.C. Mr. Colm Devine MPSI Ms. Mairead Britton Doyle
Legal Assessor:	Ms. Lorna Lynch S.C.
Appearances:	
For the Registrar:	Ms. Elaine Finneran, B.L Ms Aisling Ray, Fieldfisher LLP
For the Registrant:	Ms. Dolores Keane BL Mr. Fabian Cadden, Cadden & Company Solicitors
Registrant in attendance:	Yes
Witnesses (if applicable):	
Expert Witness:	Ms. Paula Murphy Senior Clinical Pharmacist (HSE)
Other Attendees:	Ms. Christine O'Halloran, G. Malone Stenography
In Attendance from the PSI:	Ms. Laura Gannon, Solicitor, PSI Ms. Clara O'Reilly, Regulatory Executive, PSI

Documentation:

- (i) The Core Book
- (ii) The Undertakings proposed by Mr Yorkuri
- (iii) The Medical Records of Patient A
- (iv) The Certificates of completion of courses by Mr Yorkuri

1. Subject Matter of the Complaint and Proceedings

This is a complaint of the Registrar of PSI in respect of Mr Barinedum Serrekara Yorkuri MPSI (registration number 12563). The complaint was referred by the Preliminary Proceedings Committee ('PPC') on 9 September 2021 to this Professional Conduct Committee ("PCC") on the grounds of professional misconduct and/or poor professional performance within the meaning of Section 35(1)(a) and 35(1)(b) of the Pharmacy Act 2007, respectively.

2. Preliminary Application - Anonymisation

- 2.1 An application for anonymisation was made at the outset and the members of the press present and the public were asked to depart the Inquiry Room pending the outcome of the application, but the members of the patient's family, one of whom was the Complainant, (██████) were permitted to remain.
- 2.2 Ms Finneran moved the application on behalf of the Registrar pursuant to section 42 of the Act, seeking anonymity for the Patient (Patient A), who sadly passed away in May 2022. The application also extended to the restriction of the publication of any information that would be likely to identify the Patient. It was indicated that the evidence in the Inquiry would include medical matters in respect of Patient A including her health concerns at the time of the incident, the medications that she was then receiving, and the medical attention that she received in the aftermath of the relevant incident. There was no objection from the Registrant to the application.
- 2.3 It was noted by Ms Finneran that this was not strictly a privacy application and there is no statutory basis for anonymisation, but she drew attention to the fact that it is a procedure that the Superior Courts have never been critical of and one that is regularly

adopted in matters such as this, where a hearing has proceeded in public but certain personal medical matters about a witness or a patient may be referred to. Given that personal information would be disclosed, given that Patient A was elderly at the time and is now deceased, she submitted that it would be appropriate both for the Committee to anonymise her and also to restrict the publication of any information that would tend to identify her and this may extend to identifying the names of the related family members.

3. Legal Assessor's Advice on the Preliminary Application

Ms Lynch provided her legal advice in relation to the application, noting the provisions of section 42 of the Act and advised that this was not within the four corners of a privacy application but was one that was not unusual. She noted that the Superior Courts have dealt with situations where the default position of the administration of justice in public is sought to be moved away from and in particular, referring to the *Gilchrist* decision, where the courts accepted there could be lesser forms of privacy, such as anonymisation, as is necessary in the context of the interests of justice. She advised that this case could be considered to be analogous to the context of *Gilchrist*. It was also of note that the Registrant was not objecting and that no specific public interest factors had been identified which would require the naming of the patient and her family. Therefore it was open to the Committee to accede to the application.

4. Decision of the Committee on the Preliminary Application

The Committee determined, based on the application made and the fact that it is acceded to by Counsel for the Registrant together with all the reasons outlined in the legal advice provided to the Committee, that the application for anonymisation should be permitted. This extended to the anonymisation of the patient's name and the names of her family members in order to ensure that there is a restriction on the publication of any information that would tend to identify the patient. The relevant directions relating to the anonymisation were made to the press and public by the Chair of the Committee.

5. Allegations

The allegations against the Registrant as set out in the Notice of Inquiry dated 1 December 2025 are:

“That you, whilst you were a Registered Pharmacist at Cappagh Pharmacy, Unit 5, the Shops, Barry Avenue, Finglas, Dublin 11 (“the Pharmacy”):

1. *On or about 15 April 2021, supplied and/or caused to be supplied and/or permitted to be supplied for the late [REDACTED], deceased, (“Patient A”), a blister pack of medication, containing one or more of the medications in Appendix A, in circumstances where:*
 - a. *One of more of the medications in Appendix A were not prescribed for Patient A and there was no valid prescription to authorise the supply for her; and/or*
 - b. *One or more of the medications in Appendix A were not clinically appropriate to be supplied for Patient A; and/or*
 - c. *Patient A subsequently, on or about 20 April 2021, consumed one or more of the medications in Appendix B due to the supply; and/or*
2. *Such further or other allegations as may be notified to you in advance of the Inquiry.”*

By reason of one or more of the allegations and or sub-allegations set out at 1. above, when considered in combination, it is alleged that the Registrant is guilty of poor professional performance, in that he failed to meet the standards of competence that may reasonably be expected of a registered pharmacist.”

6. Evidence

Preliminary Application - undertaking

- 6.1 Ms Finneran indicated that that it was proposed on behalf of the Registrant that he was amenable to having the matter dealt with by way of undertaking. She proposed opening the Inquiry and indicating what the Registrar's evidence would be so that the Committee could be satisfied that it had a good understanding of the nature of the case against the Registrant. Thereafter Ms Keane would move her application to ask the Committee to invite undertakings if the Committee was satisfied with this approach.

- 6.2 The Chairperson stated that it was appropriate for Ms Finneran to open the case on behalf of the Registrar, then hear from Ms Keane, and at the appropriate stage, the Committee could take legal advice from the Legal Assessor in relation to the application.

The Registrar's submissions:

- 6.3 Ms Finneran opened the Notice of Inquiry and indicated that *inter alia* the Registrar would call an expert witness, Ms. Paula Murphy, Senior Clinical Pharmacist in the HSE who had prepared a report (Core Book at tab 10). Ms Finneran noted that the complaint was initially referred by the PPC on both grounds of professional misconduct and poor professional performance, but the allegations are only of poor professional performance as Ms. Murphy's proposed evidence was that, if the allegations are found to be proven as to fact, that taken together these allegations amounted to poor professional performance.
- 6.4 Ms Finneran outlined that in April 2021 the Registrant was a registered pharmacist Mount Jubilee Trading Company Limited trading as Cappagh Pharmacy, Finglas, ("the Pharmacy") whose registered Superintendent Pharmacist is Fergal Cadden. The Committee were advised that a separate complaint against the pharmacy owner was unsubstantiated and would be addressed accordingly in due course.
- 6.5 The complaint was made by the daughter of Patient A, who at the given time of the dispensing error in April 2021 was 82 years of age and suffering from early onset Alzheimer's disease, COPD and an irregular heartbeat. Patient A lived with her daughter, her grandson and his girlfriend. Patient A passed away in May 2022.
- 6.6 Counsel indicated that the witnesses for the Registrar would comprise the Complainant (Witness B), her sister, also a daughter of Patient A and carer for her mother (Witness C) and the girlfriend of Patient A's grandson (Witness D).
- 6.7 Witness C would give evidence that on the morning of the 15 April 2021, she attended at Cappagh Pharmacy to collect Patient A's medication, which came in blister pack form and was handed to her in a bag by a female member of staff and that she did not check it. Patient A took eight tablets in the morning, two in the afternoon, and three at night.

She did not start taking the collected medication for a few days as she had not finished her prior medication.

- 6.8 Witness D would give evidence that she was in the house with Patient A on the morning of the 20 April 2021, when Patient A reported to her that she was after taking the wrong tablets. When Witness D examined the blister pack, she saw that there was the same first name but a different surname on the label of the blister pack. Witness D would say that Patient A as a result of taking the wrong medication was upset, was nervous, and she said she was afraid to move. Witness D stayed with her, but also texted Witness C to inform her what had transpired.
- 6.9 Witness C immediately contacted the pharmacy to tell them what had happened. The pharmacy asked her to bring Patient A to the pharmacy so that she could have her blood pressure checked, which she did. The Registrant checked her blood pressure. The owner of the pharmacy, Mr. Cadden, also visited Patient A at home to see how she was, and whilst he was there, Patient A became drowsy and unwell. An ambulance was called to take Patient A to Connolly Hospital. She was discharged from the hospital later that same day. The following day (21 April 2021) members of Patient A's family asked the Registrant to come to her house to check her blood pressure. He was unable to do so as there was nobody else in the pharmacy. That same day, Patient A became drowsy again and was brought back to hospital by ambulance, where she was admitted for a number of days.
- 6.10 Ms Finneran directed the Committee to two discharge summaries from Connolly Hospital. It was noted on the form for 20 April 2021 that the patient had an accidental ingestion of incorrect medication, single-dose Ramipril and Xanax. The discharge note in respect of the 21 April 2021 admission noted that Patient A was admitted with abdominal pain and diarrhoea, and that the working diagnosis was either colitis or diverticulitis. That Patient A underwent a CT of her abdomen and pelvis, which showed an abnormal growth in her small intestine, and she was discharged on 30 April 2021 as medically stable with a plan to be followed up as an outpatient and for community palliative care input.

6.11 Ms Finneran referred to the observations of the Registrant of 13 June 2021 in relation to the complaint wherein he notes the accidental dispensing of a blister pack belonging to another patient with the same first name as Patient A, attaching an incident report and he apologised for the confidentiality breach. His narrative recounted that when Witness C came to collect Patient A's weekly medication one of the pharmacy technicians went to the patient box and picked one week of blister packs from a different patient's box and asked him if the blister pack was ready, which he confirmed it was. This was handed to Witness C without checking it was the correct patient. He acknowledged this could have been avoided if the patient's address was reconfirmed at the point of dispensing. He noted that the Pharmacy SOPs have since been revised to ensure no reoccurrence of the dispensing error that transpired.

6.12 Ms Finneran also noted the action steps the Registrant had taken (on 20 April 2021) once notified of the error which included: asking the family to bring Patient A to the pharmacy to check her blood pressure, he measured it three times and it was normal; he advised the family of the most concerning effects of the medication would be low blood pressure, advising that if she felt dizzy to ring the Pharmacy or call an ambulance immediately; and for Patient A to skip the morning dose of her regular medicines as they also contained blood pressure lowering medication. He apologised for the dispensing error; notified his supervising pharmacist who would call on the patient that afternoon; he called in the afternoon to check how the patient was; and he also sent an email to Patient A's GP attaching an error report and list of medications, confirming Patient A took only one dose of the morning medication (being: one tablet of Xanax, one tablet of Lodopin, one tablet of Aspirin, Ramipril, and Kliogest). This was verified by the GP records.

6.12 Ms Finneran referred to the account of the Registrant regarding 21 April 2021, which date was not the subject of any allegation in the Notice of Inquiry and he confirmed that he rang Patient A's daughter to check on the patient to hear that she was feeling drowsy and her blood pressure was still low. A few hours later, Witness C came into the pharmacy and requested that he accompany her to their home to measure her mother's blood pressure. The Registrant couldn't leave the pharmacy as he was the only pharmacist on duty but the Pharmacy Manager, Chloe O'Brien, who was trained to check

blood pressure accompanied Witness C to her home to check Patient A and while she was there an ambulance had to be called again.

6.13 Ms Finneran noted the observations submitted by Mr Cadden, Supervising Pharmacist, including reference to the robust new procedure for giving out blister packs, the fact that Patient A continued after the incident to get her medication at the Pharmacy and the learnings for the Pharmacy and the Registrant.

6.14 Ms Finneran referred to the expert report of Ms Murphy wherein she confirmed that in her opinion, in the overall context of this single isolated incident, the allegations when taken together amounted to poor professional performance. Mr Murphy set out her opinion that the Registrant had failed to adhere to the Code of Conduct in two areas – supervision and safe delegation. Ms Finneran referred to Ms Murphy's conclusion that there was a deficit in supervision and adherence to standard practice on this occasion.

6.15 On behalf of the Registrar, Ms Finneran noted that the proposed undertakings fall within that statutory framework and that the Registrar is supportive of the undertakings that are proposed. Further, it was explained to the Complainant, who was present at the hearing, both the undertaking process and also the proposed undertakings, and her view was that it is an appropriate acknowledgement of the incident that occurred. Ms Finneran noted that the Complainant was keen to have matters finalised given the passage of time since this incident and also the death of her mother in the interim.

The Registrant's submissions:

6.16 Ms Keane set out the undertakings that Mr Yorkuri was offering, namely;- not to repeat the conduct to which the complaint relates, specifically the he will personally check that the correct blister pack which accords with the prescription authorising supply is provided for a patient when he is on duty in a pharmacy. Secondly, he agreed to complete the Irish Institute of Pharmacy courses (i) Medication Without Harm, and (ii) the Polypharmacy Medication Review and thirdly, he consented to being admonished by the Council.

6.17 Ms Keane noted that the Registrar is supportive of the Committee dealing with the complaint by way of requesting an undertaking and a consent to admonishment by Mr.

Yorkuri, and it was her understanding that the Complainant was not opposed to the giving of such undertakings.

6.18 Ms Keane provided details of the Registrant's background including that he completed his undergraduate and postgraduate degree at the Royal College of Surgeons in 2018 and has been working as a pharmacist for eight years. There has been no prior or subsequent incidents involving his practice. On his behalf, Ms Keane noted that Mr Yorkuri accepted and understood the problems that gave rise to the complaint, he has insight into his failings and intends that they shall never be repeated. She stated that he is deeply sorry for what happened and offers again at the Inquiry a fulsome apology to the Complainant regarding the medication that was wrongly handed out for her mother and his failing in his supervision of that dispensing. Ms Keane referred to his acceptance a sanction is appropriate.

6.19 Ms Keane submitted that the sanction of admonishment would be the proportionate sanction in all the circumstances in order to protect the public from any risk of harm, to promote health and safety, to promote public confidence in the profession and the delivery of pharmacy services and to promote and maintain proper professional standards.

8. Legal Assessor's Advice

8.1 Ms. Lynch outlined that the matter fell to be considered under the provisions of Section 46 of the 2007 Act, as amended. She noted that the detail of the proposed undertaking had been provided, the Registrant was prepared to give the undertaking and the Registrar had indicated her support for and the appropriateness of the undertaking. Ms Lynch advised the Committee that it was for them to decide if it was an appropriate case to request an undertaking. Ms Lynch advised that if the Committee requested an undertaking and it was given, the legal effect is that the complaint is at an end and there are no findings against the Registrant.

8.2 Ms. Lynch advised the Committee that in approaching the question of an undertaking it must initially decide if it was in a position to make an informed decision in the

circumstances. The Committee must then consider whether it was an appropriate case to request an undertaking and the Committee must have the issue of public protection in the forefront of its mind. She noted that the fact undertakings were being urged upon the Committee by Counsel for the Registrant as the appropriate way to deal with this matter, is not determinative. Ms Lynch advised that the position of the Complainant and indeed family members who are also present, is something the Committee should have regard to but is not determinative and the decision is ultimately a matter for the Committee itself. She noted that factors highlighted by Ms Keane such as the passage of time since these events, the unblemished career of the Registrant prior to and since these events and the fact this was an isolated dispensing error and not part of a pattern of conduct, his insight and apologies, were matters which should be taken account of by the Committee.

- 8.3 Ms Lynch advised the Committee that it should also consider the particular wording of the undertakings that had been proposed and that it was open to the Committee to propose alternative wording or requirements if it felt it was appropriate to do so. She noted that the proposed undertakings fell within the ambit of section 46.1 of the Act.

9. Decision of the Committee

- 9.1 The Committee considered this matter, the papers before the Committee, the opening of the Inquiry and the submissions by Ms Finneran for the Registrar, the submissions by Ms Keane for the Registrant and the legal advice received by the Legal Assessor, Ms Lynch.
- 9.2 The Committee decided that it had sufficient information before it to enable the Committee to reach a decision about whether or not to request an undertaking in this case and to consider the terms of the undertaking offered.
- 9.3 The Committee considered the circumstances of the complaint and the Notice of Inquiry which included one factual allegation together with sub-allegations and an allegation of poor professional performance.

9.4 The Committee expressed its sympathy to the patient's family and extended family members on the passing of Patient A in May 2022.

9.5 The Committee decided that this was an appropriate case to request an undertaking pursuant to Section 46 of the Pharmacy Act 2007 as amended. The reasons for that decision are as follows:-

1. The Committee noted that the allegation against Mr Yorkuri concerned a dispensing error in April 2021 which should not have occurred and led to adverse consequences for Patient A. However, the Committee had regard to the fact that it was an isolated error.
2. The Committee took into account the full and repeated apology by Mr Yorkuri had given at the time of the error and which apology was repeated through his Counsel at the Inquiry.
3. The Committee had regard to Mr Yorkuri's unblemished career and that this was the only fitness to practice complaint that has been made against him. There has been a passage of time since the events at issue and during that time, Mr Yorkuri has continued to work as a pharmacist without complaint, which must be considered together with his previous unblemished career.
4. The Committee was satisfied that Mr Yorkuri has displayed a level of insight. The Committee noted the proactive steps by Mr Yorkuri at the time of the error to deal with the patient and her family and his recent completion of courses in an effort to address identified deficiencies in his practice.
5. The Committee was satisfied that Mr Yorkuri does not intend to and is unlikely to repeat the conduct complained of. The Committee also noted that the Pharmacy immediately implemented a revised SOP to protect against this type of error reoccurring.

6. The Committee was satisfied that there was no evidence of public protection risks on foot of Mr. Yorkuri's current practice as a pharmacist.
7. While not determinative, the Committee took account of the fact that the Registrar is supporting the matter being dealt with by way of undertaking and that the Complainant is also satisfied that it is an appropriate way to deal with the matter
- 9.6 The Committee considered the wording of the proposed undertakings. The Committee was satisfied that the undertakings offered were appropriate and satisfy the requirements for protection of the public interest.
- 9.7 The Committee considered the fact that Mr Yorkuri had already completed the courses envisaged in the proposed undertakings. The Committee decided that it was appropriate to include a requirement for Mr Yorkuri to complete the courses again in 12 months' time in April 2027.
- 9.8 Mr Yorkuri provided the following undertakings to the Committee.
1. *First, not to repeat the conduct to which the complaint relates. Specifically, the he will ensure to personally check that the correct blister pack, which accords with the prescription authorising supply, is provided for a patient when he is on duty in a pharmacy.*
 2. *Second, undertakes to complete the following IOP courses or their equivalent in the month of April 2027 or such other two courses as are otherwise agreed with the Registrar, (a) Medication Without Harm, and (b) Polypharmacy and Medication review.*
 3. *Third, consents to be admonished by the Council of the PSI.*

SIGNED:



Susan Ahern SC
Chairperson

DATE:

22 July 2026