PSI
The Pharmacy Regulator
An Rialtóir Cógaisíochta

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



Introduction - Summary Details

Registered pharmacist:	Mr. James Casey MPSI
Pharmacist Registration Number:	10995
Complaint Reference(s):	677.2022
Date of Inquiry:	16 January 2025
Public/Private Hearing:	Public
Meeting Format:	PSI House, Fenian Street, D2
Members of Committee:	Ms. Susan Ahern S.C. Ms. Barbara O'Connell MPSI Ms. Mairead Britton Doyle
Legal Assessor:	Mr. Aillil O'Reilly S.C

Appearances:

For the Registrar:	Mr. Hugh McDowall, B.L Ms Dena Keane, Fieldfisher LLP
For the Registrant:	Ms. Maria Dillon, Horan & Sons Solicitors
Registrant in attendance:	Yes
Witnesses (if applicable):	[redacted] Mr Michael Lyons MPSI BL – Expert Witness (Registrar) Mr James Casey MPSI Mr Noel Stenson MPSI – Expert Witness (Registrant)
Other Attendees:	Ms Ellen Marie Ward, Ms D. O'Malley Stenography
In Attendance from the PSI:	Mr Ciaran Lyng, Solicitor, PSI Ms Clara O'Reilly, Regulatory Executive, PSI

Documentation:

1. The Core Book ("**the Core Book**") of documentary evidence considered at the Inquiry; and
2. The transcript of the Inquiry.

1. Subject Matter of the Complaint and Proceedings

1.01 This is a complaint of the Registrar of PSI in respect of Mr. James Casey, MPSI (registration number 10324). The complaint was referred by the Preliminary Proceedings Committee ('PCC') on 18 July 2024 pursuant to Section 40(1)(b)(i) of the Act to the 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. Applications

2.01 One application was made during the hearing by Ms. Dillon, Solicitor for the Registrant. She requested that the details in relation to the circumstances of the Registrant's personal situation which would be addressed in the Inquiry, not be reported.

2.02 Owing to the presence of personal and private material related to people that were not the subject of the Inquiry, and the sensitive nature of that material, the Committee ruled that none of the contents of the letter contained in pages 307 and 308 of the Core Book should be made public, and further that anything emanating from those pages shall not be disclosed publicly and directed members of the media present accordingly.

3. Allegations

3.01 The Allegations against the Registrant as set out in the Notice of Inquiry dated 19 June 2025 are*:*

That the Registrant, whilst a Supervising Pharmacist and/or Registered Pharmacist at [redacted] (the **"Pharmacy"**), on or about 30 August 2021, and in circumstances where a number of pre-filled syringes containing Innohep 4500iu solution for injection had been partially used and returned to the Pharmacy in their original casing and

packaging (the **"Returned Medication"**) by another patient (**"Patient A"**) and placed on top of the designated Pharmacy returns bin in the returns area (the **"Returns Area"**):

1. Removed the Returned Medication from the Returns Area; *and/or*

2. Failed to check that the seal on some or all of the Returned Medication had not been broken*; and/or*

3. Removed from the Returned Medication the label(s) relating to Patient A and placed the Returned Medication on the dispensary shelf for picking; *and/or*

4. By reason of one or more of the allegations contained at 1 and/or 2 and/or 3 above, the Registrant failed to comply with the Pharmacy's Standard Operating Procedures:

    a. SOP 3.9 Sharps Disposal; *and/or*
    b. SOP 3.10 Medicines Disposal; and/or

5. Such further or other allegations as may be notified to you in advance of the Inquiry.

[6.] AND FURTHER by reason of allegation 1 above, the Registrant is guilty of:

a. Professional misconduct in that he acted in a manner that is in breach of Principles 1 and/or 2 and/or 5 of the Code of Conduct for Pharmacists, 2019; *and/or*

b. Poor professional performance in that he failed to meet the standards of competence that may be reasonably expected of a registered pharmacist; *and/or*

[7.] AND FURTHER by reason of allegation 4 above, the Registrant is guilty of:

a. Professional misconduct in that the Registrant acted in a manner that:

    i) is infamous and/or disgraceful in a professional respect; *and/or*

    ii) is in breach of Principles 1 and/or 2 and/or 5 of the Code of Conduct for Pharmacists, 2019; and/or

b. Poor professional performance in that the Registrant failed to meet the standards of competence that may be reasonably expected of a registered pharmacist; *and/or*

[8.] AND FURTHER by reason of one or more of the allegations and/or sub-allegations as set out at 1 and 2 and/or 3 and/or 4 above, either cumulatively and/or in combination:

a. The Registrant is guilty of professional misconduct in that you acted in a manner that:

    i. is infamous and/or disgraceful in a professional respect; *and/or*

ii. is in breach of Principles 1 and/or 2 and/or 4 and/or 5 of the Code of Conduct for Pharmacists, 2019; *and/or*

b. The Registrant is guilty of poor professional performance in that the Registrant failed to meet the standards of competence that may be reasonably expected of a registered pharmacist.

3.02 *The Committee noted that the Notice of Inquiry in addition to the numbered Allegations 1 to 4, [and Allegation 5 which was not pursued] contains a series of further allegations which are not numbered.*

- *The first of those is the Allegation which starts on page 2 of the Core Book and reads "**AND FURTHER** by reason of allegation 1 above, you are guilty of". For the purposes of this decision and for ease of reference this is referred to as **Allegation 6**.*
- *The second of the unnumbered allegations reads "**AND FURTHER** by reason of allegation 4 above, you are guilty of:". For the purposes of this decision and for ease of reference this is referred to as **Allegation 7**.*
- *The third of the unnumbered allegations reads "**AND FURTHER** by reason of one or more of the allegations and/or sub-allegations as set out at 1 and 2 and/or 3 and/or 4 above, either cumulatively and/or in combination:". For the purposes of this decision and for ease of reference this is referred to as **Allegation 8**. This numbering is broadly consistent with that used by the expert witness retained by the PSI.*

4. Evidence

4.01 The Committee noted the admissions made by the Registrant in respect of the facts alleged by the PSI in the Notice of Inquiry (and certain of the Allegations contained at Section 3, above) and as further described in the Core Book. The Committee was referred to correspondence from solicitors for the Registrant, dated 11 March 2022 (page 100-111 Core Book), which provided a detailed and comprehensive account of the subject matter of the complaint with references to accompanying CCTV footage, the actions of the Registrant, the steps taken when the issue was detected as well as an extensive apology.

4.02 By solicitors letter dated 8 January 2026, the Registrant admitted the facts alleged at Section 3 – Allegations 1, 2, 3 and 4 therein and further admitted that these admitted facts amount to professional misconduct in breach of the Code of Conduct for Pharmacists, 2019 (the "Code of Conduct") in respect of Principle 1 and/or Principle 5. The admission was accompanied by

a submission on the part of the Registrant that it was his belief at all times that the pre-filled Innohep® syringes were uncollected stock as opposed to returned stock, although he should nonetheless never to have made this assumption.

For completeness, the Registrant made no admission in respect of a breach of Principle 2 and/or Principle 4 of the Code of Conduct; made no admission in respect of professional misconduct on the ground of conduct that is infamous or disgraceful in a professional respect; and, made no admission in respect of poor professional performance.

4.03 The Committee heard the evidence of [redacted], Superintendent Pharmacist and owner of the Pharmacy, describing the circumstances in which the Pharmacy and the Registrant became aware of the removal of the Returned Medication from the Returns Area and its placing on the dispensary shelf, making it available for dispensing and also had regard to the CCTV footage. In particular, Patient A returned used Innohep® 4,500 to the Pharmacy on 27 August 2021, and a member of staff put it in the Returns Area. The Registrant on 30 August 2021, was tidying up the Returns Area, saw some Innohep® 4,500 on the returns bin and he removed it. He walked to the back of the shop, removed the label then walked to the shelf and placed it on the shelf. Thereafter, the Returned Medication was re-dispensed to another patient (the original complainant).

4.04 The Committee heard the evidence of Mr Lyons, dealing with his expert report dated 16 June 2025 and describing his expert opinion on the conduct of the Registrant.

4.05 The Committee heard evidence from Mr Noel Stenson describing his expert opinion on the conduct of the Registrant and his remediation actions.

4.06 The Committee heard from the Registrant who read his statement and apology to the Inquiry.

5. Submissions

The Registrar's submissions:

5.01 Counsel for the PSI submitted that, as a result of the admissions of the Registrant, the facts outlined and the evidence of Mr Lyons, that the Registrar had proved her case on the criminal standard of proof, i.e. beyond reasonable doubt.

The Registrant's submissions:

5.02 Solicitor for the Registrant submitted that, by way of context, it being relevant to the Registrant's thinking on the date of the incident, that the Registrant was personally blindsided by a situation involving Innohep syringes. The Committee was informed that following a profound and tragic familial loss, the Registrant was keenly aware of the importance of Innohep and there was a known shortage of that drug at the time of the incident.

5.03 The Registrant admitted what had occurred, expressed remorse (both in person and in his correspondence), explained his reasons for what occurred, namely misguided good intentions that the Innohep medicine was in short supply from the manufacturers and wholesalers at the time and emphasised that he genuinely believed that the Innohep box was one which had not been dispensed previously i.e. that it was not a returned item but was an uncollected item.

6. Legal Assessor's Advice

6.01 The Legal Assessor advised that the submissions in relation to the test for professional misconduct, poor professional performance and failure to comply with the Code of Conduct as outlined by Counsel for the Registrar, with which the Solicitor for the Registrant agreed, were accurate.

6.02 Professional misconduct in this context is defined in section 33 of the Pharmacy Act 2007 as a pattern of conduct that is a breach of the Code of Conduct, is infamous or disgraceful in a professional respect or involves moral turpitude, fraud or dishonesty of a nature or degree which bears on the carrying on of the profession of a pharmacist.

6.03 The expression 'professional misconduct' is interpreted by the Courts (as stated by Keane J in *O'Laoire v. Medical Council*, Unreported, High Court, Keane J., 17 January, 1995), as a serious falling short, whether by omission or commission, of the standards of conduct expected and it is irrelevant that such misconduct may be attributable to honest mistake. This accepted meaning includes a "*duty to protect the public against the genially incompetent as well as the deliberate wrongdoers*".

6.04 'Poor professional performance' in relation to a registrant is defined in section 33 of the Pharmacy Act 2007 as any failure of a registrant to meet the standards of competence that may be reasonably expected of a registered pharmacist.

6.05 In the Supreme Court in *Corbally v Medical Council* [2015] IESC 9, para 41, Hardiman J. held that "*only conduct which represents a serious falling short of the expected standards of the profession could justify a finding by the professional colleagues of a doctor of poor professional performance on his part, having regard in particular to the gravity of the mere ventilation of such an allegation and the potential gravity of the consequences of the upholding of such an allegation*.".

6.06 The Legal Assessor advised that poor professional performance is understood as conduct that is sufficiently serious to merit public censure or an admonishment; it does not necessarily mean only very serious conduct, but it should be conduct that is sufficiently serious to merit public censure or admonishment.

6.07 Breach of the Code of Conduct means a serious and non-trivial breach of the Code.

7. Decision of the Committee

7.01 Having considered all of the evidence and the documents before the Committee, the Committee has decided as set out hereafter.

Findings as to Fact Allegation 1, 2, 3 and 4

7.02 The Committee heard the admissions made on behalf of the Registrant, which have greatly accelerated the conduct of this hearing and the deliberations thus far of the PCC. The Committee has had the benefit of completing a review of the Core Book, including *inter partes* correspondence, and has heard the evidence of the witnesses including two expert witnesses and the submissions of the respective Parties. The Committee noted that the dispensing of the Returned Medication gave rise to the use of one Innohep® syringe by the original complainant and not more. In the correspondence, and at the Inquiry hearing, the Registrant has admitted the allegations as to fact contained at Allegations 1 to 4 in the Final Notice of Inquiry dated 19 June 2025.

7.03 That is to say, that the Registrant has admitted as to fact that:

Whilst he was a Supervising Pharmacist and Registered Pharmacist at the Pharmacy, on or about 30 August 2021, in circumstances where the Returned Medication of another patient ("Patient A") was placed on top of the designated Pharmacy returns bin in the Returns Area, he:

1. Removed the Returned Medication from the Returns Area; and
2. Failed to check that the seal on some or all of the Returned Medication had not been broken; and
3. Removed from the Returned Medication the label(s) relating to Patient A and placed the Returned Medication on the dispensary shelf for picking; and
4. By reason or one or more of the allegations contained at 1 and/or 2 and/or 3 above, he failed to comply with the Pharmacy's Standard Operating Procedures:
    a. SOP 3.9 Sharps Disposal; and
    b. SOP 3.10 Medicines Disposal.

7.05 By reason of the evidence put before the Committee, including the CCTV footage, witness accounts and the fulsome admissions of the Registrant, the Committee finds that Allegations 1, 2, 3 and 4 are established as to their facts.

Allegations 6 - Findings as to Fact

7.06 Further to paragraph 3.02 above, **Allegation 6** related to the facts contained in **Allegation 1**. Allegation 1 has been admitted as to fact by the Registrant, namely that he removed the Returned Medication from the Returns Area of the Pharmacy. Therefore, for the reasons set out in paragraph 7.05 above, the Committee finds that that Allegation 6 is established as to it facts.

Allegations 6 - Findings as to Professional Misconduct and/or Poor Professional Performance

7.07 The Registrant admitted that his actions in removing the Returned Medication from the Returns Area of the Pharmacy (Allegation 1) constituted professional misconduct in breach of Principles 1 and 5 of the Code of Conduct, corresponding to a breach of Allegation 6 (a) save as to exclude Principle 2. No admissions were made in respect of Allegation 6 (b). It was submitted on behalf of the Registrant that he honestly believed at the time of the incident that the Innohep® syringes were uncollected stock and not returned stock.

7.08 The Committee took into consideration the belief that the Registrant held at the time he removed the Innohep® from the Returns Area. While the Committee accepted that this was genuinely the Registrant's belief, it could not excuse or condone his actions, as *inter alia* standard procedures were not adhered to. In considering whether the admitted actions of the Registrant constituted a breach of the Code of Conduct, the Committee considered the

scope and purpose of each of Principle 1 (Patient Safety), Principle 2 (Act Professionally) and Principle 5 (Safe Supply of Medicines) and took cognisance of the finding of the Mr. Lyons in this regard. The Committee noted the expert's view that syringes, once removed from a pharmacy are categorised as clinical waste and that retrieving the syringes from the Returns Area was unequivocally serious even where there was no direct handling of exposed sharps.

7.09 *Principle 1* of the Code of Conduct required the Registrant to always put the patient first and to make the health, well-being and safety of the patient his primary focus. It also required that he recognise that his decisions and behaviour as a pharmacist can influence patient care even if he did not work in direct contact with that patient. His unilateral decision to retrieve and handle the Returned Medication without following established procedures or escalating the issue breached this principle. It reflected a substantial lapse in professional judgment and adherence to established procedural standards and posed a clear risk to patient safety.

7.10 *Principle 5* of the Code of Conduct required the Registrant to promote the health and well-being of patients, by acting as a leader in the safe and effective use of medicines and healthcare resources. To promote and strengthen a culture of quality and safety, acting as a role model for the safe supply and management of medicines. The evidence and admissions of the Registrant showed that he failed to demonstrate that he had satisfied Principle 5. He should have taken personal responsibility for all work carried out by him and by others working under his supervision (point 2 of Principle 5), proactively identified potential areas of risk in his practice and taken steps to mitigate these risks (point 3 of Principle 5) and assessed risk in the workplace and optimised patient care and public safety (point 9 of Principle 5).

7.11 By reason of the Registrant's admission and taking into account the nature of the Registrant's action and how it falls within the scope of Principles 1 and 5 of the Code of Conduct, the Committee finds that the removal of the Returned Medication from the Returns Area of the Pharmacy constituted professional misconduct as a result of breach by the Registrant of Principle 1 and Principle 5 (only) of the Code of Conduct. The Committee was of the view that Principle 2 (Act Professionally) which pertains to upholding the reputation of the profession by acting with integrity, when considering the actions of the Registrant and the particular facts in this case, was not one which the Registrant had traversed by his actions.

7.12 In respect of Allegation 6 (b), which pertain to poor professional performance in respect of Allegation 1, the Committee finds that the actions of the Registrant demonstrated a failure to meet the standards of competence reasonably expected of a registered pharmacist. Safe disposal of Returned Medication, particularly injectable products is a core competency. Removing a product from the Returns Area reflects a shortfall in expected professional practice. Consequently, and for the reasons identified previously in the context of professional misconduct, the Committee finds that the actions of the Registrant constitute poor professional performance.

Allegations 7 - Findings as to Fact

7.13 Further to paragraph 3.02 above, **Allegation 7** related to the facts contained in **Allegation 4.** Allegation 4 has been admitted as to fact by the Registrant, that is to say that the allegations of fact contained in Allegations 1 to 3 inclusive, constituted a failure to comply with the standard operating procedures of the pharmacy (namely SOP 3.9 sharps disposal and SOP 3.10 medicines disposal). Therefore, for the reasons set out in paragraph 7.05 above, the Committee finds that that Allegation 7 is established as to it facts.

Allegations 7 - Findings as to Professional Misconduct and/or Poor Professional Performance

7.12 The Registrant admitted that by unilaterally retrieving and handling the Returned Medicines without following established procedures (specifically SOP 3.9 and 3.10) and escalating the issue (i.e. whether they had been correctly placed in the Returns Area) and returning them to the dispensary shelf for picking constituted professional misconduct in breach of Principles 1 and 5 of the Code of Conduct, corresponding to a breach of Allegation 7 (a)(ii) save as to exclude Principle 2. No admissions were made in respect of Allegation 7 (a)(i).

7.13 In considering whether the admitted actions of the Registrant constituted a breach of the Code of Conduct, the Committee considered the scope and purpose of each of Principle 1 (Patient Safety), Principle 2 (Act Professionally) and Principle 5 (Safe Supply of Medicines), all as elaborated above (at paragraphs 7.09 and 7.10) and took cognisance of the finding of the Mr. Lyons in this regard.

7.14 The provisions of SOP 3.9 - *Sharps Disposal* - required all returned, unused or out-of-date sharps to be handled with extreme care, place directly into designated yellow bins, and disposed of appropriately once the bin was fill. The provisions of SOP 3.10 – *Medicines*

Disposal – required that any unused or out-of-date medicines returned to the Pharmacy be placed in the designated Disposal Area, handled with extreme care and be segregated for destruction. In this regard, the Committee agreed with Mr Lyons, that the SOPs when taken together set a clear standard that returned injectables are to be treated as waste immediately and managed securely until final destruction.

7.15 The Committee finds that there was a serious failure to comply with the Pharmacy's Standard Operating Procedures (namely SOP 3.9 and SOP 3.10) when the Registrant removed the Returned Medication from the Returns Area and placed the Returned Medication on the dispensary shelf for picking, and that this significant deviation from the procedures envisaged by the Pharmacy's SOPs undermined the Pharmacy's core systems for handling returned and high-risk medicines safely and constitutes professional misconduct. The Committee finds that this was a breach of Principle 1 and Principle 5 (only) of the Code of Conduct. The Committee was of the view that *Principle 2* (Act Professionally) which pertains to upholding the reputation of the profession by acting with integrity, when considered in light of the actions of the Registrant and the particular facts in this case was not one which the Registrant had traversed by his actions.

7.16 In considering whether the Registrant's acts were infamous and/or disgraceful in a professional respect (Allegation 7(a)(i)), the Committee considered that the actions of the Registrant by unilaterally retrieving and handling the Returned Medicines without following established procedures or escalating the issue undermined the coordinated efforts required for safe and effective pharmacy practice and was disgraceful, in a professional sense.

7.17 In respect of Allegation 7 (b), which pertains to poor professional performance in respect of Allegation 4, the Committee finds that the actions of the Registrant in failing to apply and adhere to SOPs governing the safe disposal of sharps and returned medicines represents a substantial departure from the standards of competence reasonably expected of a registered pharmacist, particularly one who is in a supervising role. Such performance is not only suboptimal, but also deficient in the core competencies of risk management, patient safety awareness, decision making and reflects poor professional judgment. Consequently, and for the reasons identified previously in the context of professional misconduct, the actions of the Registrant constitute poor professional performance.

Allegations 8 - Findings as to Fact

7.18 Further to paragraph 3.02 above, **Allegation 8** related to the allegations and/or sub-allegations in Allegation 1, and/or 2 and/or 3 and/or 4 either cumulatively and/or in combination. **Allegations 1 to 4** have been admitted as to fact by the Registrant and found established by the Committee (see paragraph 7.05 above).

Allegations 8 - Findings as to Professional Misconduct and/or Poor Professional Performance

7.19 In considering whether the Registrant's acts were infamous and/or disgraceful in a professional respect (Allegation 8(a)(i)), the Committee considered that the actions of the Registrant by unilaterally retrieving and handling the Returned Medicines without following established procedures or escalating the issue undermined the coordinated efforts required for safe and effective pharmacy practice and was disgraceful, in a professional sense.

7.20 Having already determined that Allegation 1 and Allegation 4 individually amounted to breaches of the Code of Conduct and specifically Principles 1 and 5 thereof, the Committee considers that the same is also the case on cumulative basis and/or when considered in combination. Therefore Allegation 8(a)(ii) amounts to professional misconduct for the reasons set out previously in this decision.

7.21 In respect of Allegation 8(b) which pertain to poor professional performance in respect of the allegations and/or sub-allegations in Allegation 1, and/or 2 and/or 3 and/or 4 either cumulatively and/or in combination, the Committee finds that the actions of the Registrant, for the reasons identified previously, constitute poor professional performance.

8. Submissions as to Sanction

The Registrar's submissions:

8.01 Counsel for the Registrar submitted that the PSI's Guide to Sanctions (5 March 2021 edition) were applicable. A copy of the Guide to Sanctions was before the Committee. The Solicitor for the Registrant agreed that the Guide was relevant.

8.02 Counsel for the Registrar submitted that the appropriate sanction in this case was a short suspension on the registration of the Registrant. This was argued to be required to mark the seriousness of the wrongdoing, the gravity of the decisions which involved injectable

medicines and breaches of the Pharmacy SOPs and to uphold public confidence in the safe supply of medicines by pharmacists.

8.03 Counsel for the Registrar submitted that a set of conditions (pursuant to Section (48)(b)(ii) of the Pharmacy 2007 Act) should also be imposed. While providing an outline in written form to the Committee he summarized the conditions as; first, that the Registrant would engage an independent and external mentor, to be approved by the Registrar, to mentor him and to engage in mentorship and training, with a particular focus on the safe and appropriate management of returned medicines and devices. Secondly, that the Registrant would comply fully with all advice, guidance and recommendations of the mentor. Thirdly, that the mentorship would remain in place for a period of six months from the Registrant returning to practice following the period of suspension, and would include at least two audits of his practice by the approved mentor. Fourthly, that the Registrant bear all costs associated with the compliance of the conditions.

8.04 It was submitted on behalf of the Registrar that the conditions and suspension reflect the seriousness of the breach and the potential that arose for harm to the public, even though obviously no harm was actually caused to anybody.

8.05 In fairness to Counsel for the Registrar it was also submitted that attention should be drawn to the fact that there are a good deal of very important mitigating factors in this case reflecting those factors referred to the Guide to Sanctions. In particular, the Committee's attention was drawn to the extensive insight shown and remediation on the part of the Registrant. Further, Counsel for the Registrar referred to the apology from the Registrant, the extent of his insight and the evidence of the Registrar's expert, Mr Lyons, as regards the steps that the Registrant has taken in relation to his practice since the event. The Registrant's unblemished record, both with the PSI and his employer, both prior to and since the incident in question were noted. Counsel for the Registrar submitted that there was a personal dimension to the wrongdoing of the Registrant.

8.06 Counsel for the Registrar submitted that although no written references or testimonials were provided, that the Committee had heard the evidence of [redacted] and referred to his impression and his positive experience working with the Registrant, and that that should be taken into account.

8.07 Finally it was submitted that none of the aggravating factors that are set out in the Sanctions Guidance document are present in this case. In particular, there is no lack of insight, there are

no previous disciplinary cases or findings, there are no previous convictions, there is no question of an abuse of trust, there is no question of any dishonesty, substance abuse, or anything of such nature.

The Registrant's submissions:

8.08 Solicitor for the Registrant submitted that, relevant to insight and remediation, an apology and open admissions were made at the earliest possible opportunity. There was extensive engagement on the part of the Registrant, who engaged fully when the issue came to light. The Solicitor for the Registrant accepted that the matter should not have happened, and submitted that the Committee has also heard the reasons why the Registrant was blindsided in relation to this particular medication and she highlighted the unusual, life defining and intensely private personal circumstances of the Registrant (the nature of which is set out in the Solicitors letter of 11 March 2022 at p308-9 of the Core Book), which resulted in the Registrant being acutely aware of the importance of the Innohep® medicine and of the shortage in [redacted] of the medicine at that time.

8.09 The Solicitor for the Registrant submitted that a proportionate and fair selection of a sanction that demonstrated as much leniency as possible towards the Registrant requires that all of the mitigating factors as contained within the Sanctions Guidance document should be taken into account.

8.10 She highlighted the insight that demonstrated by the Registrant and as recorded in the evidence of the Registrar's expert, Mr Lyons, and also by Mr Stenson in terms of the remediation undertaken and the current status of the Registrant's practice. She referred to all of the remediation, both personal remediation in terms of continuing professional development, and the remedial steps that have been taken from a risk perspective and from a governance perspective within the Pharmacy. She submitted, that the Registrar could not demonstrate any further or more extensive contrition or earlier admission or greater personal apology than had already been provided. She submitted that the toll and effect that the incident has had on the Registrant has been considerable. She referred, without any criticism of the Registrar, to the fact that the inquiry and investigation was ongoing for 4 ½ years. She submitted that the evidence of Mr Stenson of the Registrant's adherence to good practice and the absence of risk of the issue ever arising in the future.

8.11 Ms Dillon submitted that the Registrant had been qualified for 16 years, with an unblemished professional record and that this isolated issue is the only disciplinary matter ever in the

context of his employment with [redacted]. She submitted that it was only as a consequence of the very personal matter (the nature of which is set out in the Solicitors letter of 11 March 2022 at p308-9 of the Core Book) that this event occurred. She submitted that [redacted] has continued to provide significant support to the Registrant and that the Registrant remains the supervising pharmacist in a very busy inner-city community pharmacy in [redacted] where he has worked without incident either before the issue that gave rise to the subject matter of this complaint, or since that.

8.12 She submitted that [redacted] evidence constituted a strong testimony concerning the Registrant's employment, that he had undergone disciplinary proceedings with his employer, that he poses no risk to the public, or to the professional reputation of members of the profession

8.13 The Registrant's Solicitor also submitted that it would be somewhat unfair, considering all of the mitigating factors, and absence of any aggravating factors to impose the sanctions suggested by the Registrar. She described them, as being, in those circumstances, a very punitive sanction and submitted that the Registrant could not have addressed the issue any better than he did in the context of the circumstances that arose. In doing so, she made a full acknowledgement (and insight) that the issue should never have arisen in the first place.

9. Advice of Legal Assessor on Sanction

9.01 The Legal Assessor advised that the submissions in relation to the correct approach to sanctions given by Counsel for the Registrar by reference to the PSI's Guide to Sanctions (and with which the Registrant agreed) were accurate. A copy of the Guide to Sanctions was before the Committee. The Legal Assessor advised that the correct approach to sanctions in professional conduct inquiries under the Pharmacy Act 2007 focuses on public protection, maintaining professional standards, and upholding public confidence rather than punitive measures. Sanctions are generally applied in a proportionate manner, balancing the need to protect the public with the pharmacist's right to work.

9.02 The Legal Assessor advised that the Committee should apply proportionality, give sufficient weight to mitigating factors and to treat the Registrant with as much leniency as possible and take into account any insight. The least restrictive sanction should be considered first, and if not sufficient to protect the public, the next lowest sanction should be considered and the process repeated until an appropriate sanction is identified.

9.03 The Legal Assessor noted that there were no aggravating factors in this case. He also advised that the mitigating factors, identified from page 7 in the Guide to Sanctions, should be considered. He referred the Committee to the following; insight and remediation (e.g. apology); adherence to principles of good practice by the pharmacist; previous disciplinary record; circumstances leading up to any complaints (e.g. whether the complaint relates to a single, isolated incident in an otherwise unblemished career, the Registrant's level of experience); personal and professional matters; references and testimonials. The Guide to Sanctions is non exhaustive and also may not be relevant in every case. It also requires that if factors relied upon are not considered relevant or truly mitigatory, that reasons should be given.

10. Committee Recommendations on Sanction

The Committee makes the following recommendation in relation to sanction:

- That the Registrant should be suspended from the Register of Members for a period of four (4) weeks.

Reasons for recommendation:

10.01 In considering the matter of sanctions, the Committee has had cognisance of the fact that sanctions are imposed in order to: (i) protect the public from a risk of harm and to promote the health and safety of the public, (ii) promote and maintain public confidence in the pharmacy profession and the delivery of pharmacy services and its regulation, and (iii) to promote and maintain proper professional standards and conduct for the members of the profession and those who operate pharmacies.

10.02 The Committee was also cognisant that in imposing any sanction it must have regard to the principle of proportionality in deciding what sanction to impose and must choose a sanction or sanctions which do not go further than is necessary to meet the overarching objective of protecting the public, as required by the Act. In its assessment it must also afford the Registrant with as much leniency as possible in the circumstances.

10.03 The Committee had regarded the serious nature of the allegations which were admitted by the Registrant and the nature and extent of the findings that have made been by the Committee. The Committee had regard to the obligations and responsibilities on him as a Supervising Pharmacist and issues of public protection. The Committee noted that there was

no evidence of harm to any individual patient, but the Committee was of the view that the potential for harm given the particular facts in this case, were considerable and did cause extensive worry to the patient to whom the medicine was subsequently re-dispensed to and necessitated medical testing (including needle stick injury testing) to ensure that there had been no adverse outcomes. The deficiency on the part of the Registrant was such as to materially increase the risk of harm to a patient and therefore the imposition of a sanction was warranted.

10.04 It was noted by the Committee that the original complainant had sought to withdraw her complaint against the Registrant at a certain juncture, but given the seriousness of the behaviour the Registrar, of its own motion determined to proceed with the Inquiry. The Committee considered that there were no aggravating factors present in the case and this position was also freely acknowledged by Counsel for the Registrar.

10.05 The Committee had regard to a considerable number of mitigating factors in the case. In particular, the Committee considered:

(a) the admissions made by the Registrant in respect of Allegations 1 to 4 and in terms of the admitted professional misconduct through certain breaches of the Code of Conduct were early, open and comprehensive admissions;

(b) the apology made by the Registrant in the personal statement read by him at the hearing addressed to the original complainant and his colleagues wherein he admitted his deep regret, remorse and that he should have acted differently. This was but the most recent apology and an earlier one had been provided to the original complainant shortly after the incident was understood;

(c) the actions taken to ensure that the protocols, systems and internal SOPs of the Pharmacy were revised and addressed to the fullest extent possible to ensure the failing would not reoccur;

(d) The insight shown by the Registrant was clear to the Committee from the early admissions to his apologies, the correction of deficiencies in his performance and to the efforts made by him to prevent the issue recurring;

(e) This was a single action on 30 August 2021, one incident and the Registrant had no prior disciplinary record. The Committee noted the submission made regarding the comprehensive steps taken by the Registrant since 2021 to address the failings in his

practice and to improve the relevant procedures and processes in the Pharmacy, including updating SOP 3.9 and 3.10, introducing a new SOP and providing staff with relevant training.

10.06 The Committee acknowledges the genuine and very difficult nature of the personal circumstances disclosed by the Registrant to the Inquiry in the period leading up to the incident and the Registrant's heightened awareness around Innohep® from 2021. This was considered by the Committee while also conscious that the Registrant had not sought to rely upon his personal circumstances as an excuse, but rather an explanation.

10.07 The Committee allowed very limited weight to the referenced delay between the occurrence of the Incident and the Inquiry proceeding, being of the view that the natural course of disciplinary proceedings take a certain amount of time. However, the early admissions made by Mr Casey had contributed significantly to the speed of the hearing and the concomitant reduction in time and expense by all Parties.

10.08 While there were no written testimonials in support of the registered pharmacist, his employer [redacted] attended and gave highly supportive evidence at the hearing. The Committee was impressed by the content of [redacted]'s evidence and oral testimonials in support of the Registrant and in particular the fact that there is no evidence of any alleged lack of clinical competence in his practice as a pharmacist and Supervising Pharmacist. He also addressed the internal disciplinary proceedings that he undertook following the incident and how the Registrant had learned from the experience and made considerable contributions to the development of risk mitigation strategies within the Pharmacy.

10.09 The Committee considered the available sanctions.

10.10 The Committee was of the view that admonishing and/or censuring the Registrant was not a sufficient sanction to address the seriousness and extent of the findings against him.

10.11 The Committee considered what if any conditions attaching to the Registrant's practice as a pharmacist might be warranted. It also took note of the particular conditions which were proffered by the Registrar in this case, noting that these were in combination with other proposed sanctions. The Committee was of the view that conditions attaching to the Registrant's practice alone would not be sufficient to address the serious nature of the

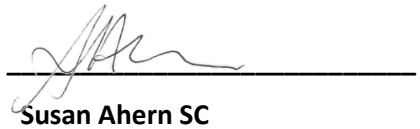
incident and the circumstances of the case. There was no evidence of any lack of insight or risk to patient care or any other matter that might be supported or improved by the imposition of conditions of any kind.

10.12 The Committee was of the view that a period of suspension is warranted to ensure that public confidence in the profession is maintained. A lesser sanction would serve no purpose in this case, and would not act as a sufficient deterrent for the wider profession. The Committee does not consider that the Registrant requires any personal deterrent. The conduct in question, although limited to a single event, presented the possibility of a high degree of risk to a patient. No harm was ultimately caused to that patient, but the Committee considers that its potential for serious harm warrants a short period of suspension for no more than four (4) weeks. The Committee believes that this would ensure that confidence in the profession is not undermined. In this regard, the Committee is mindful of the potential for long-term consequences for a Registrant posed by a period of suspension. The Committee of the opinion that the suspension should be for not more than four (4) weeks. This reflects the absence of any aggravating factors and the very extensive number of mitigating factors referred to by the Solicitor for the Registrant, none of which were contradicted by Counsel for the Registrar.

10.13 Suspension for any period of time is a serious matter for a Registrant and the Committee is conscious of this fact. The Committee believes that a longer or greater a period of suspension would be disproportionate in the circumstance and would fail to demonstrate leniency that is justified by the actions of the Registrant on discovering the occurrence; and that contributed to his particular sensitivity at the time in August 2021.

10.14 The Committee was of the view that it is not necessary or proportionate in the circumstances, in addition to the suspension to also attach conditions to the Registrant's registration in order to protect the public. The Committee was of the view that a mentoring programme was not necessary or proportionate given the remediation undertaken by the Registrant and the guidance and support available to him from [redacted]. An audit regime was similarly unnecessary and, in any event, one had been commissioned by the Registrant from Mr Stenson who gave a glowing account of the Registrant's current practice. There was no evidence of any deficit in relation to protection the public or a risk that the identified failings were not repeated. To add conditions to the suspension sanction would in the opinion of the Committee be punitive and unlikely to achieve the stated objective.

10.15 The Committee is of the view that this short period of suspension is to mark the failings on the part of the Registrant when he was the Supervising Pharmacist, to adequately protect the public interest and act as a sufficient deterrent for the Registrant and wider profession.

SIGNED: 

Susan Ahern SC

Chairperson

DATE: **4 February 2026**