THE COLLEGE OF PHARMACISTS OF MANITOBA

In the matter of: ***The Pharmaceutical Act,*** **C.C.S.M., c.P60**

And in the matter of: **Glen Pauch, a pharmacist registered with the College of Pharmacists of Manitoba**

DECISION AND ORDER OF THE DISCIPLINE COMMITTEE

Introduction

1. Pursuant to a Notice of Hearing dated May 23, 2025 (the "Notice") and an Amended Notice of Hearing dated March 10, 2026 (the "Amended Notice"), a hearing was conducted by the Discipline Committee (the "Discipline Committee") of the College of Pharmacists of Manitoba (the "College") at the offices of Thompson Dorfman Sweatman LLP, on March 17, 2026, with respect to charges formulated by the Complaints Committee of the College (the "Complaints Committee") alleging that Glen Pauch ("Mr. Pauch"), being a pharmacist under the provisions of *The Pharmaceutical Act*, C.C.S.M. c. P60 (the "Act") and a registrant of the College, is guilty of professional misconduct or conduct unbecoming a member, or has displayed a lack of knowledge or skill or judgment in the practice of pharmacy or the operation of a pharmacy, or any of the above, as described in section 54 of the Act, in that, at Pharmasave #456, 308 Saskatchewan Ave E., Portage la Prairie, Manitoba (the "Pharmacy"):

1. In respect of care provided to patient [redacted]":

    a. On multiple occasions, Mr. Pauch created a prescription record for oxycodone within the Pharmacy and an entry into DPIN without authorization from a prescriber, and dispensed oxycodone without a prescription, in contravention of sections 31(2)(b) and 37 of the *Narcotic Control Regulations,* C.R.C. c. 1041 (the "NCRs"), subsection 2(3) of the Act, sections 69(1), 78(1)(b), 78(1)(c) and 83 of *The Pharmaceutical Regulation*, Man Reg 185/2013 (the "Regulation"), section 4 of *The Pharmaceutical (General Matters) Regulation*, Man. Reg. 194/2013 (the "General Regulation"), section 2.1.3 of the *Practice Direction: Records and Information* (the "Records PD"), sections 4.1 and 4.2 of the *Practice Direction: M3P Information Entered into DPIN* (the "M3P PD"), and Statements VII and VIII of the *Code of Ethics* (the "Code"), or any of them;

    b. On multiple occasions, Mr. Pauch created a prescription record for lorazepam within the Pharmacy and an entry into DPIN without authorization from a prescriber, and dispensed lorazepam without a prescription, in contravention of subsection 51(1)(b) of the *Benzodiazepine and Other Targeted Drug Regulations* SOR/2000-217, (the "BOTSRs"), subsection 2(3) of the Act, sections 69(1), 78(1)(b) and 83 of the Regulation, section 4 of the General Regulation, section 2.1.3 of the Records PD, and Statement VII and VIII of the Code, or any of them;

    c. On multiple occasions, Mr. Pauch dispensed the narcotic drug oxycodone and the targeted drug lorazepam without regard to prescriber-specified fill

dates or authorized dispensing intervals, in contravention of subsection 2(3) of the Act, sections 69(1), 78(1)(b) and 83 of the Regulation, section 4.1 of the M3P PD, and Statement VII of the Code, or any of them;

d. On multiple occasions, Mr. Pauch failed to submit prescriptions for controlled substances to DPIN, in contravention of subsection 78(1)(c) of the Regulation, subsection 9(4) of the *Prescription Drugs Payment of Benefits Regulation* (the "Benefits Regulation"), section 4.2 of the M3P PD, section 2.1.1 and 2.1.3 of the Records PD, and Statement VII of the Code, or any of them;

e. On multiple occasions, Mr. Pauch created inaccurate prescription transaction date records of controlled substances by altering actual prescription fill dates, in contravention of subsection 2(3) of the Act, section 78(1)(b), 78(1)(c) and 83 of the Regulation, section 4.1 and 4.2 of the M3P PD, sections 2.1.1 and 2.1.3 of the Records PD, and Statements VII and VIII of the Code, or any of them;

f. On multiple occasions, Mr. Pauch created inaccurate prescription records by inaccurately entering a prescribed interval on a new oxycodone prescription and subsequent part-fills and creating an unauthorized duplicate deferred oxycodone prescription record in contravention of subsections 56(1)12 and 70(1) of the Regulation, and sections 2.1.1 and 2.1.3 of the Records PD, or any of them;

g. On multiple occasions, Mr. Pauch provided oxycodone and lorazepam in quantities which exceeded the amounts authorized by the prescriber, in contravention of subsection 2(3) of the Act, sections 69(4), 78(1)(b) and 83 of the Regulation, section 4.1 of the M3P PD, and Statement VII of the Code, or any of them;

h. Between June 2020 and October 2021, Mr. Pauch dispensed opioids and benzodiazepines with either no or insufficient intervention with the prescribing practitioner, taking into account the high dosages ordered and the frequency of administration, in contravention of subsection 2(3) of the Act, sections 56(1)3, 69(4), 78(1)(b) and 83 of the Regulation, section 4.1 of the M3P PD, sections 2.2, 2.3 and 2.4 of the *Practice Direction: Ensuring Patient Safety* (the "Patient Safety PD"), Statements II and VII of the Code, and *The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain* (the "Opioid Guidelines"), or any of them;

i. On multiple occasions, Mr. Pauch created false records of conversations with prescribers, in contravention of subsection 2(3) of the Act, sections 69(4) and 83 of the Regulation, sections 2.1.1 and 2.1.3 of the Records PD, and Statements VII and VIII of the Code, or any of them;

j. On multiple occasions, Mr. Pauch dispensed an M3P scheduled narcotic drug pursuant to a faxed prescription addressed to a different pharmacy, in

contravention of section 69 of the Regulation, the *Joint Statement: Facsimile Transmission of Prescriptions (June 2016)* and Statement VII of the Code, or either of them

k. On multiple occasions, Mr. Pauch dispensed oxycodone pursuant to a faxed prescription which failed to specify the total quantity of the drug to be dispensed in the initial fill and all part-fills, in contravention of subsection 77(c) of the Regulation and the *Joint Statement: Ensuring Safe Access to M3P Prescriptions for Patients During the Covid-19 Outbreak (April 2020)* (the "Covid Statement"), or either of them; and

l. On multiple occasions, Mr. Pauch dispensed oxycodone pursuant to a prescription order that prescribed more than one drug, in contravention of subsection 77(b) of the Regulation, and the Covid Statement, or either of them.

2. In respect of care provided to patient "[redacted]":

a. [redacted]

b. On multiple occasions, Mr. Pauch dispensed Concerta® 27mg and Apo-Methylphenidate IR 10mg without regard to prescriber-specified dispensing intervals in contravention of subsection 2(3) of the Act, sections 69(4) and 83 of the Regulation, and Statement VII of the Code, or any of them;

c. On multiple occasions, Mr. Pauch created prescription records for Concerta® 27mg, Apo-Methylphenidate ER 27mg, and Apo-Methylphenidate IR 10mg which falsely indicated authorization from the prescriber, in contravention of sections C.01.041(1) and G.03.002 of the *Food and Drug Regulations*, C.R.C. c. 870 (the "FDRs"), subsection 2(3) of the Act, sections 69(1) and 83 of the Regulation, section 4 of the General Regulation, section 2.1.3 of the Records PD, and Statements VII and VIII of the Code, or any of them;

d. On multiple occasions, Mr. Pauch failed to submit to DPIN, prescriptions for controlled drugs PMS-Methylphenidate IR 20mg, Concerta® 27mg, and Apo-Methylphenidate IR 10mg, in contravention of section 78(1)(c) and 83 of the Regulation, subsection 9(4) of the Benefits Regulation, sections 2.1.1 and 2.1.3 of the Records PD, section 4.1 and 4.2 of the M3P PD and Statement VII of the Code, or any of them;

e. On multiple occasions, Mr. Pauch created inaccurate prescription transaction date records of controlled drugs by altering actual prescription fill dates, in contravention of subsection 2(3) of the Act, section 83 of the

Regulation, sections 2.1.1 and 2.1.3 of the Records PD, and Statements VII and VIII of the Code, or any of them;

f. Mr. Pauch created an inaccurate prescription record for Concerta® 27mg, which attributed the prescription to an incorrect prescriber, in contravention of subsection 2(3) of the Act, sections 69(4) and 83 of the Regulation, and section 2.1.3 of the Records PD, or any of them;

g. Mr. Pauch created a controlled drug prescription record which indicated that he had authorized the prescription and was the prescriber, in contravention of section C.01.041 and G.03.002 of the FDRs, subsection 2(3) of the Act, sections 69(1) and 83 of the Regulation, section 4 of the General Regulation, and Statement VIII of the Code, or any of them;

h. Mr. Pauch altered a Concerta® prescription without authorization by the prescriber and failed to notify the prescriber about the alteration, in contravention of subsection 2(3) of the Act, sections 69(4) and 83 of the Regulation, and sections 2.1.1 and 2.1.3 of the Records PD, or any of them; and

i. On multiple occasions, Mr. Pauch created prescription records which falsely indicated that he had dispensed and provided Concerta® and methylphenidate IR to the patient, in contravention of section 2.1.3 of the Records PD and VII and VIII of the Code, or any of them.

3. In respect of care provided to patient "[redacted]":

a. On August 7, 2021, Mr. Pauch failed to obtain a prescription before dispensing 15 PMS-Hydromorphone 1mg tablets, in contravention of section 31(2) of the NCRs, subsection 2(3) of the Act, subsection 69(1) of the Regulation, section 4 of the General Regulation and section 4.1 of the M3P PD, or any of them;

b. Mr. Pauch failed to maintain accurate records of the PMS-Hydromorphone 1mg prescription issued to [redacted] within the Pharmacy's records and entry into DPIN, in contravention of subsection 56(1)12 of the Regulation, section 2.1.3 of the Records PD, and Statement VIII of the Code, or any of them; and

c. [redacted]

4. In respect of care provided to patient "[redacted]":

a. On multiple occasions, Mr. Pauch failed to ensure adherence to prescribed intervals on hydromorphone prescriptions and dispensed Hydromorph Contin® prior to the valid date of the prescription, in contravention of

subsection 2(3) of the Act, subsection 69(4) of the Regulation, and section 4.1 of the M3P PD, or any of them;

b. [redacted]

c. In July 2020, Mr. Pauch dispensed 25 Apo-hydromorphone 4mg tablets without a prescription and without creating a prescription record in the Pharmacy's records and entry into DPIN, in contravention of sections 31(2), 38 and 40.1 of the NCRs, subsection 2(3) of the Act, subsections 56(1)12, 69(1), 70(1), 71(3), 78(1) and 79(2) of the Regulation, section 4 of the General Regulation, subsection 9(4) of the Benefits Regulation, sections 4.1 and 4.2 of the M3P PD and sections 2.1.1 and 2.1.3 of the Records PD, or any of them;

d. Between June and July 2020, on multiple occasions, Mr. Pauch failed to ensure that prescription and patient information was submitted to DPIN when filling hydromorphone IR 2mg prescriptions, in contravention of subsection 2(3) of the Act, subsection 78(1)(c) of the Regulation, subsection 9(4) of the Benefits Regulation, and section 4.2 of the M3P PD, or any of them;

e. [redacted]

f. [redacted]

5. In respect of care provided to patient "[redacted]":

a. On May 12, 2021, Mr. Pauch dispensed ten Apo-Oxycodone CR 15mg tablets without a prescription, in contravention of subsection 31(2) of the NCRs, subsection 2(3) of the Act, sections 69(1), 78(1) and 83 of the Regulation, section 4 of the General Regulation, section 4.1 of the M3P PD, or any of them;

b. On May 12, 2021, Mr. Pauch created an improper and inaccurate Apo-Oxycodone CR 15mg prescription record in the Pharmacy record and entry into DPIN, in contravention of section 4.1 of the M3P PD, section 2.1.3 of

the Records PD, and Statement VIII of the Code, or any of them; and

c. On May 12, 2021, Mr. Pauch submitted a false prescription claim to DPIN and to Manitoba Family Services for OxyNeo® 15mg when dispensing generic Apo-Oxycodone CR 15mg, in contravention of subsection 2(3) of the Act, subsections 56(1)12 and 78(1)(c) of the Regulation, subsection 9(4) of the Benefits Regulation, section 4.2 of the M3P PD, sections 2.1.1 and 2.1.3 of the Records PD, and Statement VIII of the Code, or any of them.

6. In respect of care provided to patient "[redacted]":

a. On multiple occasions, Mr. Pauch dispensed hydromorphone 1 mg, Sandoz-Hydromorphone 2mg/mL injection and Nozinan 25 mg/mL injection without a prescription, in contravention of subsection 31(2)(b) of the NCRs, subsection 2(3) of the Act, sections 69(1), 78(1) and 83 of the Regulation, section 4 of the General Regulation and section 4.1 of the M3P PD, or any of them;

b. On November 27, 2020, Mr. Pauch dispensed Apo-hydromorphone 1 mg prior to the authorized dispensing date, in contravention of sections 69(4) and 83 of the Regulation, or either of them;

c. In November 2020, Mr. Pauch created improper and inaccurate Sandoz-Hydromorpone 2mg/mL and Nozinan 25 mg/mL prescription records in the Pharmacy record and entry into DPIN, in contravention of section 4.1 of the M3P PD, section 2.1.3 of the Records PD, and Statement VIII of the Code, or any of them; and

d. In November 2020, Mr. Pauch dispensed Apo-hydromorphone 1mg without obtaining a prescription directly from the prescriber, in contravention of subsections 77 and 78 of the Regulation, and *Prescription Copies: Pharmacist Obligations & Considerations (2014)*, or any of them.

7. In respect of care provided to patient "[redacted]":

a. In July 2021, on multiple occasions, Mr. Pauch dispensed Vyvanse® 40mg without a prescription, in contravention of sections C.01.041(1)(a) and G.03.002 of the FDRs, subsection 2(3) of the Act, subsection 69(1) of the Regulation and section 4 of the General Regulation, or any of them;

b. On July 2, 2021, when Mr. Pauch dispensed five Vyvanse® 40mg tablets, he failed to create and maintain a prescription record, in contravention of section G.03.007 and G.03.010 of the FDRs, subsections 56(1)12, 70(1), 71(3) and 79(2) of the Regulation, and section 2.1.1 of the Records PD, or any of them; and

c. On July 6, 2021, Mr. Pauch created an improper and inaccurate Vyvanse® 40mg prescription record in the Pharmacy record and entry into DPIN, in

contravention of subsection 9(4) of the Benefits Regulation, section 2.1.3 of the Records PD, and Statement VIII of the Code, or any of them.

8. In respect of care provided to patient "[redacted]":

    a. Between September and November 2020, on multiple occasions, Mr. Pauch failed to create and maintain prescription records when dispensing Teva-Morphine SR 60mg and Teva-Oxycocet, in contravention of sections 38 and 40.1 of the NCRs, subsections 56(1)12, 70(1), 71(3), 79(2) and 83(e) and (g) of the Regulation, and section 2.1.1 of the Records PD, or any of them;

    b. Between September and November 2020, on multiple occasions, Mr. Pauch failed to ensure that prescription and patient information was submitted to DPIN when dispensing Teva-Morphine SR 60mg and Teva-Oxycocet, in contravention of subsections 78(1)(b), 78(1)(c), 83(e) and 83(g) of the Regulation, subsection 9(4) of the Benefits Regulation and section 4.2 of the M3P PD, or any of them; and

    c. Between September and November 2020, on multiple occasions, Mr. Pauch dispensed Teva-Morphine SR 60mg and Teva-Oxycocet without ensuring that the prescribed dosing intervals had elapsed, in contravention of sections 69(4) and 83 of the Regulation, or either of them.

9. In respect of care provided to patient "[redacted]":

    a. On multiple occasions, Mr. Pauch created improper and inaccurate prescription records for controlled drugs by altering actual prescription fill dates, in contravention of section G.03.007(e) of the FDRs, subsection 56(1)12 and 70(1)(h) of the Regulation, section 2.1.3 of the Records PD and Statements VII and VIII of the Code, or any of them;

    b. In January 2021, Mr. Pauch created improper and inaccurate records of dispensing methylphenidate, in contravention of subsection 2(3) of the Act, sections 78(1)(b) and 83 of the Regulation, section 4.1 of the M3P PD, section 2.1.3 of the Records PD, and Statements VII and VIII of the Code, or any of them;

    c. Between December 2020 and January 2021, Mr. Pauch failed to ensure that prescription and patient information was submitted to DPIN when filling M3P scheduled drugs, in contravention of subsection 2(3) of the Act, sections 56(1)12, 78(1)(c) and 83 of the Regulation, subsection 9(4) of the Benefits Regulation, sections 4.2 and 4.2.1 of the M3P PD, section 2.1.1 of the Records PD, and Statements VII and VIII of the Code, or any of them; and

    d. Mr. Pauch failed to ensure the security of controlled substances at the Pharmacy by creating falsely dated prescription records and failing to enter

transactions for controlled substances into DPIN, in contravention of section G.03.012 of the FDRs and Statement VIII of the Code, or either of them.

10. In respect of care provided to patient "[redacted]":

    a. On July 8, 2021, Mr. Pauch dispensed 10 Hydromorph Contin® 6mg tablets without written authorization from the prescriber, in contravention of subsection 31(2) of the NCRs, subsection 2(3) of the Act, sections 69(1), 78(1)(b) and 83 of the Regulation, section 4 of the General Regulation and section 4.1 of the M3P PD, or any of them; and

    b. On July 8, 2021, Mr. Pauch created an improper and inaccurate Hydromorph Contin® 6mg prescription record in the Pharmacy record and entry into DPIN, in contravention of subsection 2(3) of the Act, subsections 56(1)12 and 78(1)(c) of the Regulation, section 4.2 of the M3P PD, and sections 2.1.1 and 2.1.3 of the Records PD, or any of them.

11. In respect of care provided to patient "[redacted]":

    a. On October 26, 2020, Mr. Pauch dispensed nine Hydromorph Contin® 3mg tablets without written authorization from the prescriber, in contravention of section 31(2) of the NCRs, subsection 2(3) of the Act, sections 69(1), 78(1)(b) and 83 of the Regulation, section 4 of the General Regulation, and section 4.1 of the M3P PD, or any of them;

    b. On May 28, 2021, Mr. Pauch dispensed 150 Apo-Hydromorphone 2mg tablets without written authorization from the prescriber, in contravention of sections 31(2) and 37 of the NCRs, subsection 2(3) of the Act, sections 69(1), 78(1)(b) and 83 of the Regulation, section 4 of the General Regulation, and section 4.1 of the M3P PD, or any of them;

    c. On August 14, 2021, Mr. Pauch dispensed 150 Apo-Hydromorphone 2mg tablets without written authorization from the prescriber, in contravention of sections 31(2) and 37 of the NCRs, subsection 2(3) of the Act, sections 69(1), 78(1)(b) and 83 of the Regulation, section 4 of the General Regulation, and section 4.1 of the M3P PD, or any of them;

    d. On May 27, 2021, Mr. Pauch created an improper and inaccurate prescription record when he entered an unauthorized and deferred Apo-Hydromorphone 2mg prescription in the Pharmacy record, in contravention of subsection 56(1)12 of the Regulation, and sections 2.1.1 and 2.1.3 of the Records PD, or any of them; and

    e. On multiple occasions, Mr. Pauch created improper and inaccurate prescription records in the Pharmacy record and entered into DPIN showing unauthorized prescriptions for M3P narcotic drugs, in contravention of section 38 of the NCR, subsection 2(3) of the Act, subsections 56(1)12,

70(1) and 78(1)(c) of the Regulation, section 4.2 of the M3P PD, and sections 2.1.1 and 2.1.3 of the Records PD, or any of them.

12. Between June 2020 and October 2021, Mr. Pauch failed to protect controlled substances within the Pharmacy and removed from pharmacy inventory multiple doses of narcotic, controlled and targeted drugs, or any of them, via fraudulent manual adjustments, in contravention of section 43 of the NCRs, section G.03.012 of the FDRs, subsection 72(1)(a) of the BOTSRs, sections 2.3.2.1, 2.3.2.3, 2.3.2.4 and 2.3.2.5 of the *Practice Direction: Drug Distribution and Storage* (the "DDS PD"), sections 2.1.1, 2.1.2 and 2.1.3 of the Records PD, the *Narcotic and Controlled Drugs Accountability Guidelines* (the "Narcotic Guidelines") and Statements VIII and X of the Code, or any of them.

13. On multiple occasions between June 2020 and October 2021, Mr. Pauch failed to ensure all unexplained shortages of narcotic, controlled and targeted drugs were reported to Health Canada's OCS in contravention of section 42 of the NCRs, section G.03.013 of the FDRs, subsection 72(2) of the BOTSRs, section 2.3.2.5 of the DDS PD, and the Narcotic Guidelines, or any of them.

14. On multiple occasions between June 2020 and October 2021, Mr. Pauch failed to ensure all unexplained shortages of narcotic, controlled and targeted drugs were reported to the College in contravention of section 2.3.2.5 of the DDS PD, and the Narcotic Guideline, or either of them.

15. On multiple occasions, for a total of 8,500 doses, Mr. Pauch failed to ensure that a record of the receipt of M3P scheduled controlled substances was created at the Pharmacy, in contravention of sections 30 and 43 of the NCRs, sections G.03.001(1), G.03.001(2) and G.03.012 of the FDRs, sections 75 and 79(2)(e) of the Regulation, section 2.3.1 of the DDS PD, sections 2.1.1, 2.1.2 and 2.1.3 of the Records PD and Statement VIII of the Code, or any of them.

16. On multiple occasions for a total of 8,500 doses, Mr. Pauch failed to ensure that the receipt of controlled substances was entered into the Pharmacy's perpetual inventory, in contravention of section 43 of the NCRs, section G.03.012 of the FDRs, sections 2.3.1 and 2.3.2.1 of the DDS PD, sections 2.1.1, 2.1.2 and 2.1.3 of the Records PD, the Narcotic Guidelines, and Statement VIII of the Code, or any of them.

17. On multiple occasions, Mr. Pauch failed to maintain records to show the receipt of M3P scheduled controlled substances from a supplier, in contravention of section 43 of the NCRs, sections G.03.001(1), G.03.001(2) and G.03.012 of the FDRs, sections 75 and 79(2)(e) of the Regulation, section 2.3.1 of the DDS PD, sections 2.1.1, 2.1.2 and 2.1.3 of the Records PD, and Statement VIII of the Code, or any of them.

18. Between June 2020 and October 2021, Mr. Pauch failed to maintain an accurate perpetual inventory of regular, unsalable and patient-returned controlled substances within the Pharmacy, in contravention of section 43 of the NCRs, section G.03.012 of the FDRs, section 72(1)(a) of the BOTSRs, sections 2.3.2.1 and 2.3.2.2 of the DDS PD and the Narcotic Guidelines, or any of them.

19. [redacted]

20. Between June 2020 and October 2021, Mr. Pauch failed to ensure that the disposal of pharmacy-generated and patient-returned controlled substances was done in accordance with prescribed guidelines and documented, in contravention of sections 2.1.1., 2.1.2 and 2.1.3 of the Records PD and the Narcotic Guidelines, or any of them.

21. Between June 2020 and October 2021, on multiple occasions, Mr. Pauch failed to ensure the security of narcotic and/or controlled substances in the Pharmacy by failing to enter the receipt of hydromorphone powder into an inventory record, failing to maintain a perpetual inventory of the drug, and failing to include hydromorphone powder in inventory verification counts, in contravention of sections 30 and 43 of the NCRs, sections 2.3.1, 2.3.2.1 and 2.3.2.2 of the DDS PD, sections 2.1.1 and 2.1.3 of the Records PD and the Narcotic Guidelines, or any of them.

22. Between June 2020 and October 2021, Mr. Pauch failed to ensure the drug destruction process for hydromorphone powder was documented, witnessed and attested to by two regulated health care professionals, in contravention of sections 43 and 45(2) of the NCRs, section 2.3.1 of the DDS PD, sections 2.1.1 and 2.1.3 of the Records PD and the Narcotics Guidelines, or any of them.

23. Between February and October 2021, Mr. Pauch improperly compounded hydromorphone oral solution, in contravention of subsection 56(1)8 of the Regulation, sections 2.1.1 and 2.1.3 of the Records PD and the *NAPRA Model Standards for Pharmacy Compounding of Non-sterile Preparations*, or any of them.

24. On multiple occasions, Mr. Pauch created prescription records within the Pharmacy and in DPIN which indicated that he had dispensed PMS-Hydromorphone 1mg/mL Oral Solution, when he had provided compounded hydromorphone oral solution, in contravention of subsection 38(d) of the NCRs, sections 2(3) and 78 of the Act, subsections 56(1)12, 70(1)(c) and 78(1)(c) of the Regulation, section 2.1.1 and 2.1.3 of the Records PD, and section 4.2 of the M3P PD, or any of them.

25. On multiple occasions, while licensed and working as a pharmacist at the Pharmacy, Mr. Pauch consumed unprescribed controlled substances, in contravention of Statements I, VII, VIII and X of the Code, or any of them.

26. Mr. Pauch failed to report to the Registrar of the College that he was suffering from a mental condition and had a diagnosis of an opioid-use disorder, which might interfere with his ability to practice in a safe and effective manner in contravention of sections 5, 14(f) and 16 of the Regulation, and Statements I, VII, VIII and X of the Code, or any of them.

27. [redacted]

a. [redacted]

b. [redacted]

28. Mr. Pauch breached his written undertaking to the College by working at the pharmacy known as "PortageRX", in a non-pharmacist role, while his pharmacist license was surrendered, in contravention of sections 34(1) and 38 of the Act, and Statements VIII and X of the Code, or any of them.

29. [redacted]

30. [redacted]

2. The hearing into these charges convened on March 17, 2026. Mr. Jeffrey Hirsch and Ms. Sharyne Hamm appeared as counsel for the Complaints Committee. Ms. Jennifer Sokal appeared as counsel for Mr. Pauch, who also attended in person. Mr. Thomas Reimer appeared as counsel for the presiding panel of the Discipline Committee (the "Panel").

3. The Complaints Committee and Mr. Pauch jointly submitted a Statement of Agreed Facts (the "Statement"), which was entered into evidence as Exhibit 2. In the Statement, Mr. Pauch admitted the following, with respect to jurisdiction, service, panel composition and practice and discipline history:

I. Jurisdiction, Service and Panel Composition

a. He is a member of the College.

b. He received valid service of the Notice and the Amended Notice.

c. The College has complied with the requirements of ss. 46(2) and 46(3) of the Act.

d. He has no objection to any of the Panel members , nor to legal counsel to the Panel, whether on the basis of bias, reasonable apprehension of bias, or conflict of interest.

II. Practice and Discipline History

e. Mr. Pauch graduated with his pharmacy degree from the University of Manitoba in 2009.

f. Mr. Pauch has been registered as a pharmacist under the Act since July 9, 2009. At all material times, Mr. Pauch was a registrant of the College.

g. Mr. Pauch's known employment history is as follows:

   i. Beginning in July 2009, he was employed as a staff pharmacist at Rexall Pharmacy in Sioux Lookout, Ontario. He became the Pharmacy Manager of this location in January 2010 and remained in this position until August 2011;

   ii. Between August 2011 and June 2012, Mr. Pauch was the Pharmacy Manager at Rexall Pharmacy in Altona, Manitoba;

   iii. Between June 2012 and April 2020, Mr. Pauch held various roles at the Shoppers Drug Mart #544, 124 Saskatchewan Ave E, in Portage la Prairie, Manitoba. Mr. Pauch was staff pharmacist, pharmacy manager and Associate Owner at different times;

   iv. Between September 2014 and September 2018, in addition to his role at Shoppers Drug Mart #544, Mr. Pauch also acted as staff pharmacist, pharmacy manager and Associate Owner at various times at the Shoppers Drug Mart in The Pas, Manitoba;

   v. From June 2020 to October 2021, Mr. Pauch was a staff pharmacist at PharmaSave Pharmacy in Portage la Prairie (the "Pharmacy"); and

   vi. Between July 2023 and November 2023, Mr. Pauch was a staff pharmacist at PortageRx in Portage la Prairie subject to the conditions and Monitoring Program Undertaking as described below.

h. Mr. Pauch voluntarily surrendered his pharmacist licence on October 27, 2021.

i. On July 26, 2023, Mr. Pauch entered a Monitoring Program Undertaking with the College which permitted him to return to practice. Upon his return to practice, Mr. Pauch had the following conditions placed on his license:

   i. He was required to abstain from ingesting any controlled drugs unless approved in advance by the College and, if prescribed a controlled drug or substance by a physician, would require the approval of the College before beginning the course of treatment;

   ii. He was required to participate in monthly in-person counselling sessions, with monthly reporting to the College;

   iii. He was required to submit for 12 annual randomized drug and alcohol screenings, of which three samples annually would be hair samples;

   iv. He was required to ensure that the pharmacy manager in any pharmacy in which he was employed would conduct and document a complete narcotic and controlled drug reconciliation on a monthly basis; and

   v. He was not permitted to be a pharmacy manager or preceptor.

j. On November 21, 2023, Mr. Pauch was suspended from practice on an interim basis. On March 17, 2026, the date of the hearing, he remained suspended from practice.

k. Mr. Pauch has no previous discipline history with the College.

III. Admissions and Plea

4. Mr. Pauch admitted to having reviewed the Amended Notice and the Statement, which he and counsel for the Complaints Committee signed. He admitted the truth and accuracy of the facts in the Statement and that the witnesses and other evidence available to the College, if called and otherwise tendered, would be substantially in accordance with these facts.

5. Mr. Pauch tendered no evidence and made no submissions on the issue of professional misconduct, other than to admit that the conduct described in the Statement demonstrates professional misconduct, conduct unbecoming a member, and a display of a lack of knowledge or skill or judgment in the practice of pharmacy or the operation of a pharmacy as described in section 54 of the Act.

6. Mr. Pauch entered a guilty plea to Counts 1, 2(b), 2(c), 2(d), 2(e), 2(f), 2(g), 2(h), 2(i), 3(a), 3(b), 4(a), 4(c), 4(d), 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 23, 24, 25, 26 and 28 (the "Charges") set out in the Amended Notice.

7. The Complaints Committee entered a stay of proceedings with respect to counts 2(a), 3(c), 4(b), (e) and (f), 19, 27, 29 and 30 of the Amended Notice.

8. Mr. Pauch agreed that his admissions and guilty plea were voluntary, informed and unequivocal. He also confirmed that he understood that by pleading guilty, he has given up his right to contest the factual accuracy of the Charges.

9. Mr. Pauch agreed that, with respect to the Charges, his conduct constituted professional misconduct, conduct unbecoming a member, a breach of the legislation, practice directions, Code of Ethics (the "Code") and guidelines (as particularized in the Charges), and a display of a lack of knowledge, skill or judgment in the practice of pharmacy or the operation of a pharmacy.

IV. Disposition

10. Legal counsel for the Complaints Committee and for Mr. Pauch made a joint recommendation with respect to an appropriate disposition on penalty. At the hearing on the Charges, the Panel advised the parties that it accepted the disposition on penalty, with written reasons to follow. Those written reasons are set out below.

11. The joint recommendation did not address the issue of costs, which was the subject of submissions from each of the Complaints Committee and Mr. Pauch. The Panel's order and written reasons on costs is also set out below.

V. Decision and Order

12. Considering the evidence contained in the Statement, together with Mr. Pauch's admissions of guilt, the Panel accepts that the Charges have been established. It therefore finds Mr. Pauch guilty

of professional misconduct, as described in s. 54 of the Act, and makes the following orders, pursuant to ss. 55 and 56 of the Act:

a. A suspension from practice for 30 months, with credit of 28 months for the time during which Mr. Pauch was interim suspended between November 21, 2023 and March 21, 2026. For clarity, Mr. Pauch will be suspended from practice until May 20, 2026;

b. A fine of $25,000;

c. Restrictions on his practising licence for five years, to be effective from the date of his return to practice following the suspension that he will be prohibited from being a pharmacy manager or preceptor;

d. A requirement that he complete, at his cost and with an unconditional pass, the PROBE Ethics course, by no later than March 31, 2027;

e. Mr. Pauch will enter into an undertaking with the College which will include terms related to the following:

i. He will complete a 360-hour internship before being permitted to return to practice, which is to be supervised by a preceptor approved by the College, and with bi-weekly reporting to the College;

ii. He will be limited to 35 hours per week of pharmacy practice in total across any pharmacies in which he may be employed, for a period of one year commencing upon the completion of his internship;

iii. Upon the completion of his internship, Mr. Pauch will be prohibited from the sole practice of pharmacy and cannot work in a pharmacy without another pharmacist present in the dispensary for a period of two months, immediately following which he will be prohibited from the sole practice of pharmacy without another person present for a subsequent six months;

iv. The pharmacy manager in any pharmacy in which Mr. Pauch is employed shall provide reporting to the College on the following basis:

1. Monthly, for a period of three months following completion of the internship; and

2. Quarterly, for the following nine months;

v. Unless approved in advance in writing by the College, or in emergency situations where prescribed and the College is promptly notified, he will abstain from consuming any controlled drugs for a period of two years;

vi. At his cost, he will submit to up to 12 random drug and alcohol screenings annually, for a period of two years, which shall be at the direction of the College and/or CBI Health and of which, four samples annually will be hair samples;

vii. He will participate in monthly in-person counselling sessions with a qualified therapist and/or addictions counsellor, with reporting to the College on a monthly basis, for a period of one year;

viii. He will be required to advise the pharmacy manager in all pharmacies which employ him that monthly reconciliation counts of narcotics, controlled drugs, and targeted drugs must occur; and

ix. He will be required to advise the pharmacy manager in all pharmacies which employ him of the restrictions on his licence.

f. Mr. Pauch is ordered to pay a contribution toward the costs of the investigation and hearing in the amount of $75,000.00.

g. Mr. Pauch will have five years from the date of this decision to pay the fine and contribution to costs ordered in subparagraphs (b) and (f), respectively.

h. There will be publication of the conviction, penalty and circumstances of the offences, including publication of Mr. Pauch's name.

VI. Reasons for Decision

13. In reaching its decision, the Panel considered the Statement, the joint recommendation, the submissions of the parties, the affidavit of Dr. Brent Booker affirmed March 17, 2026.

14. These reasons will deal separately with the issues of acceptance of the joint recommendation and costs, following a summary of the facts and background giving rise to the Charges.

A. Summary of Facts

15. The Panel accepts the Statement in its entirety. The following is a summary of key points taken from the Statement, which was lengthy. By his guilty plea, Mr. Pauch has admitted that the facts in the Statement breached the various provisions of the Act, regulations, guidelines, Code provisions and other directives cited in the Charges. For the sake of brevity, these documents and provisions will not be repeated in the summary below.

Count 1

16. Count 1 relates to Mr. Pauch's treatment of patient [redacted], [redacted], between June 2020 and October 2021. [redacted] was initially prescribed oxycodone and lorazepam by [redacted] treating physician. On multiple occasions, Mr. Pauch created prescription records and dispensed oxycodone to [redacted] without a valid prescription or prescriber authorization. 2,174 tablets of oxycodone were removed from the Pharmacy's inventory as a result. He did the same with lorazepam on several occasions, resulting in removal of 480 lorazepam 1mg tablets from inventory without a proper prescription. It is unclear from the evidence how many of these oxycodone and lorazepam tablets were dispensed to the patient or whether any of them were diverted.

17. During this period, Mr. Pauch also regularly dispensed oxycodone and lorazepam to [redacted] earlier than authorized by the prescriber, who confirmed to the investigator that [redacted] had never

approved of such early releases because [redacted] was trying to reduce [redacted]'s narcotic and controlled substances use.

18. Mr. Pauch also falsified pharmacy records in a variety of ways, including by backdating prescription fill dates, altering prescription quantities and intervals without prescriber authorization, failing to enter prescriptions into DPIN, and, on one occasion, duplicating a prescription record. Mr. Pauch also fabricated notes that purported to record discussions and authorizations from the prescriber that never happened. He also filled prescriptions sent to another pharmacy for [redacted], he filled prescriptions that lacked required information, and he dispensed oxycodone pursuant to a prescription order that prescribed more than one drug.

19. Mr. Pauch's misconduct resulted in [redacted] receiving oxycodone in amounts that far exceeded the maximum authorized by the prescriber and that went far beyond the Canadian Opioid Guidelines' recommended dosages. Mr. Pauch failed to intervene with the prescriber, as he was obligated to with respect to [redacted]'s excessive lorazepam and oxycodone use. After [redacted] ceased being a patient at the Pharmacy, [redacted] entered an Opioid Agonist Therapy ("OAT") program and was ultimately able to stop using opioid drugs.

Count 2

20. Count 2 concerns Mr. Pauch's treatment of patient [redacted], [redacted] Mr. Pauch has admitted to creating multiple prescription records without valid authorization from a prescriber, dispensing medications using incorrect or ineligible prescriber names (such as a doctor who had left practice in Manitoba). On one occasion, Mr. Pauch issued a continued care prescription for a Concerta® prescription, something he was not authorized to do for controlled drugs. He also substituted immediate-release methylphenidate for Concerta® without authorization. The immediate-release version of the drug is more likely to be diverted and abused because it can be easily crushed and then snorted or injected. Mr. Pauch also backdated several prescription fill dates for [redacted] and failed to submit multiple transactions to [redacted]'s DPIN.

21. Most concerning to the Panel, on multiple occasions Mr. Pauch falsely created prescription records that indicated he had dispensed Concerta® or methylphenidate to [redacted]. Although [redacted] denied receiving the drugs recorded in these false records, the drugs were still removed from the Pharmacy's inventory.

Count 3

22. Mr. Pauch has admitted that he dispensed hydromorphone, purportedly to an elderly patient [redacted], without a valid prescription. The prescription was filled after the Pharmacy had closed on August 7, 2021, and was falsely attributed to a prescriber who did not order the prescription.

Count 4

23. With respect to Count 4, Mr. Pauch has admitted that in providing care to patient [redacted], [redacted], he repeatedly dispensed hydromorphone refills earlier than authorized, made an unauthorized change to a prescription, and failed to ensure that prescription and patient information was submitted to DPIN as required.

Count 5

24. In connection with Count 5, Mr. Pauch has admitted that he falsely used a prescriber's name to create a prescription under which he dispensed 10 Apo-Oxycodone CR 15mg tablets for patient [redacted]. After he filled the false prescription, the prescriber expressly told Mr. Pauch it was not authorized; however, Mr. Pauch failed to tell the prescriber that he had already filled it.

25. The misconduct relating to this patient was aggravated by the fact that the drug that Mr. Pauch provided to the patient was not covered by the patient's government drug plan, because it can be easily crushed, and then snorted or injected. To get around this, Mr. Pauch submitted a false claim to DPIN and to Manitoba Family Services using a Drug Identification Number for a different drug that was covered under the patient's drug plan.

Count 6

26. Count 6 relates to an elderly patient who had no prior history with the Pharmacy. On November 24, 2020, Mr. Pauch dispensed 10 Apo-Hydromorphone 1mg tablets to [redacted] without a prescription. Mr. Pauch claimed that he did so because the patient's [redacted] was a "very close friend". When a prescription did arrive a short time later, it was faxed to the Pharmacy from another pharmacy to which it had actually been addressed. In other words, Mr. Pauch accepted an inter-pharmacy transfer of a narcotic prescription, something that is prohibited by legislation.

27. Mr. Pauch then rebilled the prescription, changed the date, updated the prescriber's directions and changed the quantity to 30 tablets. Although the prescriber instructed that the second part-fill of the prescription was not to be issued until 15 days had passed, Mr. Pauch filled the balance of the prescription after only three days without authorization from the prescriber.

28. Mr. Pauch also created false prescriptions for this patient for 20 mL of injectable Sandoz-Hydromorphone 2mg/mL and 10 mL of methotrimeprazine (Nozinan®) 25 mg/mL. Mr. Pauch also admits to dispensing these drugs without a prescription.

Count 7

29. Count 7 concerns a [redacted] patient with no history at the Pharmacy. On July 2, 2021, Mr. Pauch dispensed five Vyvanse® 40mg tablets to this patient without a prescription and without creating any prescription record. On July 6, 2021, Mr. Pauch dispensed a further five tablets without a prescription. This time, Mr. Pauch falsely created a prescription record which he attributed to [redacted], a physician to whom the Pharmacy had faxed an authorization request. [redacted] did issue a prescription on July 7, 2021, but Mr. Pauch failed to advise [redacted] that he had already dispensed ten tablets of Vyvanse® to [redacted] before the prescription was authorized. There was no documentation suggesting that Mr. Pauch had spoken to [redacted] on or around July 2 or July 6, 2021. The prescription record entered by Mr. Pauch in the Kroll system and in DPIN was therefore incorrect.

Count 8

30. Count 8 relates to Mr. Pauch's provision of care to patient [redacted]. Mr. Pauch has admitted that on multiple occasions between September and November 2020, he failed to create and maintain prescription records when dispensing Teva-Morphine SR 60mg and Teva-Oxycocet. He also failed

to ensure that prescription and patient information was submitted to DPIN for these medications and failed to ensure that proper dispensing intervals had elapsed before filling part refills. On one occasion, the prescription contained firm instruction that part-fills were only to be dispensed after 30 days – an instruction that Mr. Pauch ignored.

Count 9

31. In connection with Count 9, Mr. Pauch has admitted that, in providing service to patient [redacted], he created improper and inaccurate prescription records for methylphenidate by altering prescription fill dates, he failed to ensure that prescription and patient information was submitted to DPIN, and he failed to ensure security of controlled substances at the Pharmacy. Mr. Pauch backdated one methylphenidate transaction by nearly three months.

Count 10

32. Mr. Pauch has admitted that he dispensed 10 Hydromorph Contin® 6mg tablets to patient [redacted] without written authorization from the prescriber and then created an improper and inaccurate prescription record in the Pharmacy record and DPIN.

33. Initially Mr. Pauch dispensed 10 tablets without prescriber authorization. When he received a prescription the next day, it was for 180 tablets, which was eventually dispensed in three 60-tablet instalments. Mr. Pauch did not make an adjustment for the 10 tablets that he dispensed without authorization.

Count 11

34. Count 11 relates to care provided to patient [redacted]. On October 26, 2020, Mr. Pauch dispensed [redacted] nine Hydromorph Contin® 3mg tablets without a valid prescription. The Kroll workflow report showed that Mr. Pauch entered the transaction on October 29, 2020, and backdated it. Mr. Pauch did not fax a request to the prescriber or otherwise obtain consent to dispense the medications.

35. On October 29, 2020, the prescriber faxed a prescription for Hydromorph Contin® 6mg tablets. By backdating the fill of the 3mg tablets, Mr. Pauch concealed the fact that he had dispensed the previously prescribed dosage tablets on the same day that the prescriber had increased the dosage.

36. On two separate occasions in May and August 2021, Mr. Pauch dispensed Apo-Hydromorphone 2mg tablets to this same patient without written authorization. He also created an improper and inaccurate prescription record for these unauthorized fills, which included false statements that the Pharmacy's computers were not working and that the prescribing physician was away.

37. Mr. Pauch has also admitted that on three occasions he created improper and inaccurate prescription records in the Pharmacy record and in DPIN that showed prescriptions for M3P narcotic drugs that had not been authorized by the prescriber, despite Mr. Pauch falsely recording that they had been. On one of the three occasions, ten days elapsed between the date on which Mr. Pauch dispensed the narcotic drug and the date the next prescription arrived from the prescriber. On two of the three occasions, the prescriber later provided faxed prescriptions that were significantly different from what Mr. Pauch dispensed.

Count 12

38. Count 12 relates to Mr. Pauch's failure, between June 2020 and October 2021, to protect controlled substances within the Pharmacy and his fraudulent removal of multiple doses of narcotic, controlled and targeted drugs from the Pharmacy inventory.

39. Although he was not pharmacy manager, Mr. Pauch assumed many of the responsibilities relating to narcotic accountability procedures, including ordering and receiving controlled substances.

40. A key tool for a pharmacy to protect its controlled substances, is an accurate perpetual inventory verified by regular physical counts. This gives a viewer a "snapshot" of the exact quantity of the controlled substances in stock at the pharmacy at a given time. When drugs need to be removed to account for expiry, damage or errors, among other things, manual adjustments can be made by pharmacy staff to ensure the values remain accurate.

41. Mr. Pauch has admitted to making negative manual adjustments to the Pharmacy's perpetual inventory (i.e. the inventory was adjusted to "remove" the drug from the perpetual inventory) on 81 occasions involving over 5,000 doses where Mr. Pauch used false or misleading explanations, reasons that were false, misleading, implausible or in conflict with other Pharmacy documents or where he used no reason at all. Many of these adjustments involved various brands of hydromorphone, methylphenidate, targeted benzodiazepines and oxycodone.

Counts 13 and 14

42. In connection with Counts 13 and 14, Mr. Pauch has admitted to a pattern of failing to ensure that all unexplained shortages of narcotic, controlled and targeted drugs were reported to Health Canada's Office of Controlled Substances and to the College. This happened on approximately 143 occasions between June 2020 and the end of 2021.

Counts 15, 16 and 17

43. These counts relate to Mr. Pauch's failure to ensure that proper records of the receipt of controlled substances were kept and maintained at the Pharmacy, including proper adjustments to the perpetual inventory. Mr. Pauch has admitted to failing to create receipt records, and to adjust the perpetual inventory to reflect receipt of 8,500 doses of controlled substances. These doses remain unaccounted for.

44. In connection with these counts, Mr. Pauch has admitted to one incident, on February 16, 2021, in which he manually adjusted the perpetual inventory to show receipt of only 100 PMS-Methylphenidate 20mg tablets, when 200 tablets were indicated on the invoice signed by Mr. Pauch. On the same date, Mr. Pauch manually adjusted the perpetual inventory to show receipt of 200 tablets of Dilaudid® 8mg, when 600 tablets were indicated on the invoice signed by Mr. Pauch. There were no records to show what happened to the 500 tablets signed for by Mr. Pauch but omitted from the perpetual inventory adjustments. This is one of several instances documented in the Statement where narcotic, controlled and targeted substances went missing without explanation after being handled by Mr. Pauch. The Panel finds this incident, and this pattern of incidents, to be highly concerning.

Counts 18 & 20

45. Count 18 relates to Mr. Pauch's failure to maintain an accurate perpetual inventory of regular, unsalable and patient-returned controlled substances between June 2020 and October 2021. These categories of controlled substances must be counted at regular, mandated intervals. Mr. Pauch has admitted that he agreed to be responsible for completing these counts. The Pharmacy had no records that tracked unusable controlled substances that were unsalable or that were returned by patients for destruction.

46. Count 20 relates to Mr. Pauch's failure to ensure that expired and returned narcotic and controlled drugs were properly destroyed to prevent their consumption.

Counts 21 & 22

47. In relation to Count 21, Mr. Pauch admits that, on multiple occasions between June 2020 and October 2021, he failed to ensure the security of narcotic or controlled substances in the Pharmacy by failing to enter receipt of hydromorphone powder into an inventory record, failed to maintain a perpetual inventory of the drug, and failed to include hydromorphone powder in inventory verification counts.

48. In relation to Count 22, Mr. Pauch admits that during this same timeframe, he failed to ensure that the drug destruction process for hydromorphone powder was documented, witnessed and attested to by two regulated healthcare professionals.

49. In connection with these two counts, Mr. Pauch admits that he placed three orders totalling 22,000 mg of hydromorphone powder that were never entered into any record or into the perpetual inventory system at the Pharmacy. During the relevant period an additional 3,000 mg of hydromorphone powder were ordered and received from another supplier. Of this 25,000 mg of hydromorphone powder, 19,223 mg was unaccounted for after Mr. Pauch left the Pharmacy in October 2021. This is another extremely troubling incident where narcotic or other medications handled by Mr. Pauch went missing without explanation. The amount of hydromorphone unaccounted for in this case is staggering.

50. Mr. Pauch admitted to destroying some leftover hydromorphone powder, but did not follow proper procedures or create documentation, as he was required to.

Count 23

51. Mr. Pauch admits to improperly compounding hydromorphone oral solution between February and October 2021. During this period, the PMS brand of hydromorphone oral solution that the Pharmacy used became unavailable. The Pharmacy therefore began compounding hydromorphone oral solution using hydromorphone powder. The applicable standards and regulations require specific information to be kept about a pharmacy's compounding work, yet Mr. Pauch regularly compounded hydromorphone oral solution without properly documenting or keeping records of his preparation.

Count 24

52. Count 24 relates to Mr. Pauch's admission to creating prescription records within the Pharmacy and DPIN which indicated the dispensing of brand-name hydromorphone oral solution,

when he had provided compounded hydromorphone oral solution. Even though he knew it was incorrect to do so, on multiple occasions Mr. Pauch billed hydromorphone compound as the commercial brand-name product.

Count 25

53. Mr. Pauch has admitted in relation to Count 25 that, on multiple occasions while he was licensed and working as a pharmacist at the Pharmacy, he consumed unprescribed controlled substances. Pharmacy staff reported to the pharmacy manager, Ms Giercke, that Mr. Pauch would spend 20 minutes at a time in the bathroom while he was the only pharmacist on duty, and with patients waiting. Ms Giercke was confident that Mr. Pauch was injecting drugs in the bathroom. She reported him appearing disheveled and hearing from staff that he appeared to be impaired while at work. On one occasion, a pharmacy assistant reported finding a syringe cap in the bathroom after Mr. Pauch had been in there. [redacted] suspected that he was injecting drugs between his toes because he would sometimes return to the dispensary barefoot and would appear impaired. [redacted] also told the investigator that that the Pharmacy's patients would often complain about being shorted on narcotics and that Mr. Pauch handled these complaints himself.

Count 26

54. In connection with Count 26, Mr. Pauch has admitted that he failed to report to the College that he was [redacted]), which might have interfered with his ability to practice in a safe and effective manner. Because the chronology of events relating to this Count is important, it will be summarized in some detail.

55. Mr. Pauch was a registered pharmacist in Manitoba between 2009 and 2023. He held a licence with the College from 2009 to October 27, 2021, when he voluntarily surrendered his licence, and then again between July and November 2023, when he was interim suspended.

56. On December 1, 2021, as part of the voluntary surrender of his licence, Mr. Pauch completed a Mental Health and Addictions Initial Assessment with CBI Health ("CBI"). CBI's report indicated that Mr. Pauch had reported never using or diverting narcotics in his lifetime, and no other substance use other than occasional alcohol and marijuana use. However, the investigation was provided with evidence that Mr. Pauch had overdosed and been hospitalized, and that his friends had found drugs and drug paraphernalia in his home, which they had thrown away.

57. Mr. Pauch was diagnosed with [redacted] in or around January 2022 and began treatment with [redacted] on January 26, 2022, under a prescription from a physician at [redacted]. Beginning February 2, 2022, Mr. Pauch began [redacted]. He received [redacted] from February to June 2022.

58. In January 2022, the College received a second complaint from Ms Giercke about potential diversion of methylphenidate by Mr. Pauch. At the Complaints Committee's direction, Mr. Pauch attended a meeting on January 28, 2022, where he was directed to provide a hair sample to CBI for drug screening.

59. Mr. Pauch then arranged for his own drug testing with another testing provider on February 7, 2022. That test was positive for codeine, hydromorphone and hydrocodone.

60. [redacted] attempted to contact Mr. Pauch on February 7, 8 and 9, 2022, to arrange to receive hair test samples. Mr. Pauch did not respond. On February 10, 2022, Dr. Booker wrote to Mr. Pauch to advise that the Committee would be informed of his non-compliance with the direction to arrange testing at [redacted].

61. On March 21, 2022, the Committee directed Mr. Pauch to attend another meeting with the Complaints Committee, scheduled for April 12, 2022, and to report to [redacted] for testing without delay. Mr. Pauch was not responsive to several further attempts from [redacted] to arrange for the test, nor did he follow Dr. Booker's direction, made on April 1, 2022, to do so. Mr. Pauch attended the meeting with the Complaints Committee on April 12, 2022, where he was again directed to attend to testing with [redacted] immediately.

62. [redacted] made three further unsuccessful attempts to reach Mr. Pauch in April 2022, but Mr. Pauch was unresponsive.

63. The next event the Statement refers to happened approximately 11 months later, when Mr. Pauch requested reinstatement of his pharmacist licence on March 14, 2023. The Complaints Committee invited Mr. Pauch to attend a meeting to discuss his request and his health status.

64. Mr. Pauch attended the meeting and agreed to provide samples to [redacted]. Hair and urine samples provided on May 29, 2023, were negative with the exception that the hair sample tested positive for low to moderate alcohol consumption. [redacted] noted that the accuracy of the test may have been affected by the fact that the hair sample was severely damaged.

65. On June 30, 2023, Dr. Booker wrote to Mr. Pauch to advise him that the Committee had approved his request for a gradual return to practice, under conditions that included participation in counselling and randomized substance screening with [redacted].

66. On July 13, 2023, Mr. Pauch entered into an undertaking with the College in connection with his return to practice, and on July 26, 2023, his pharmacist licence was reinstated. He then began working as a pharmacist at [redacted] under supervision.

67. On September 21, 2023, Mr. Pauch underwent a drug screen at [redacted] that was positive for amphetamine and low to moderate alcohol consumption. Mr. Pauch was advised of the positive test on October 5, 2023, and directed to attend an urgent meeting with the Complaints Committee the next day.

68. At the meeting, Mr. Pauch denied consumption of any amphetamines. He suggested that he had possibly inhaled second-hand smoke and claimed a false positive based on consumption of a cough suppressant.

69. Mr. Pauch was directed to attend another drug screen on October 11, 2023. Although he complied with that direction, the hair sample was exceptionally damaged, which prevented the lab from obtaining any results. Mr. Pauch was told to provide a further hair sample, which he did on November 7, 2023. That drug screen was positive for codeine, hydromorphone and alprazolam.

70. Dr. Booker then advised Mr. Pauch that the College was considering an interim suspension of his pharmacist licence. He was directed to attend a further urgent meeting at the College on November 20, 2023.

71. At the meeting, Mr. Pauch denied using codeine, hydromorphone and alprazolam, and again stated that he had only taken cough suppressants since October 2023.

72. On November 21, 2023, Mr. Pauch was notified that his pharmacist licence had been interim suspended. After a further meeting on December 4, 2023, Mr. Pauch was advised that the interim suspension would be maintained.

73. In addition to the denials at the various meetings with the Complaints Committee in 2022 and 2023, Mr. Pauch also declared in his application for his 2021 pharmacist licence that he did not currently or previously have a condition that may have impaired his ability to engage in pharmacy practice in a safe and effective manner. Mr. Pauch did not update this declaration before he voluntarily surrendered his licence on October 27, 2021.

74. When he applied for reinstatement of his pharmacist licence in July 2023, Mr. Pauch failed, among other things, to disclose that he was the subject of an investigation relating to his suitability to practice pharmacy. After being directed to amend his application to reflect the true situation, Mr. Pauch checked the box for a current or past condition, but he handwrote in the margin "No current condition". He did not specify whether the condition was physical, mental or an addiction.

75. Mr. Pauch also told the College's investigator on December 16, 2024, that he had not used unauthorized opioids before October 2021, and that he misused drugs between October 2021 and January 2022.

76. This chronology is set out in detail because it shows that Mr. Pauch had several opportunities to disclose his [redacted] to the College over the course of several years, but failed to do so until July 2025 – nearly four years after he voluntarily surrendered his licence in October 2021.

Count 28

77. Count 28 relates to Mr. Pauch's breach of his written undertaking to the College. On October 27, 2021, Mr. Pauch voluntarily surrendered his licence and undertook not to practice pharmacy or work in a pharmacy. However, in October 2022, Mr. Pauch began working at a newly registered pharmacy called [redacted], though apparently not in the dispensary. Whether he worked in the dispensary or not, however, working in a pharmacy in any capacity was a breach of his undertaking.

B. Joint Recommendation on Penalty

78. Following the hearing of this matter, the Panel advised the parties of its decision to accept the joint recommendation with written reasons to follow.

79. A disciplinary panel should not depart from a joint recommendation unless it is of the view that the joint recommendation would bring the administration of justice into disrepute or is otherwise contrary to the public interest.

80. The penalty proposed in the joint recommendation is significant, involving a lengthy suspension, the maximum fine allowed by the Act, reasonable and necessary restrictions on Mr. Pauch's licence, and an undertaking that protects the public, while also allowing Mr. Pauch an opportunity for rehabilitation. The Panel finds that the penalty proposed in the joint recommendation is proportionate to the severity of Mr. Pauch's misconduct, which was extensive and serious.

81. The Panel accepts the submission of the Complaints Committee that Mr. Pauch's admitted misconduct raises a high likelihood that narcotic and controlled substances were diverted. The volume of narcotic, controlled, and targeted drugs – at least 39,300 doses according to the Complaints Committee's count – is alarming. Mr. Pauch's pattern of misconduct, which unfolded over 16 months, included many kinds of violations, including drugs being dispensed without prescriptions, unauthorized early partial fills, false records of communication with prescribers, backdating of patient records, and provision of drugs in greater quantities and dosages than was authorized by prescribers. Mr. Pauch has also admitted to manipulating the perpetual inventory and failing to record receipt of hydromorphone powder. Many of these breaches have an element of dishonesty and evasion. The Panel finds that Mr. Pauch put patients at risk of harm through his misconduct.

82. The Panel notes, as mitigating factors, that Mr. Pauch has no previous disciplinary history and that he has pled guilty to the Charges, which saved the parties and the Panel the time and expense that would have been associated with a lengthy hearing. The Panel also acknowledges that during the relevant time, Mr. Pauch was dealing with his father's illness and death and with the breakdown of his marriage.

83. Both parties recognized during their submissions that Mr. Pauch suffered from an [redacted]) during the relevant time. Neither party made submissions about whether the Panel should treat Mr. Pauch's [redacted] as a true mitigating factor in the sentencing analysis, likely because the sentence was subject of a joint recommendation.

84. In the Panel's view, before it could treat [redacted] as a mitigating factor for sentencing, medical evidence about the causal connection between Mr. Pauch's [redacted] and his misconduct would be needed. As late as December 2024, Mr. Pauch was denying unauthorized use of opioids before October 2021. Most of the Charges to which Mr. Pauch has pled guilty relate to misconduct that happened before October 2021, and before his diagnosis of [redacted] in January 2022.

85. The Panel finds that Mr. Pauch's failure to be candid and honest with the College about his misconduct and his [redacted], and his failure to scrupulously comply with his undertaking to the College, bear specific denunciation. Mr. Pauch had many opportunities – and a professional obligation – to acknowledge his [redacted] to the College but did not do so until July 2025, nearly four years after the College began investigating and approximately two months after the initial Notice was issued by the Complaints Committee. In fact, had a College investigator not come across Mr. Pauch's [redacted] by happenstance while investigating another matter in August 2024, Mr. Pauch's [redacted] may never have come to light. The events described in the Statement in relation to Counts 26 and 28 demonstrate uncooperativeness and, at times, deception on the part of Mr. Pauch.

86. The Panel has reviewed and considered the cases submitted by the parties in relation to the sentence. The Panel finds that the penalty jointly recommended by the parties is generally consistent with previous cases involving similar facts.

87. By way of conclusion on sentence, the Panel accepts the joint recommendation and finds that the recommended penalty is proportionate to Mr. Pauch's misconduct and meets the objectives of sentencing, including specific and general deterrence, the need to maintain public confidence in the integrity of the profession's ability to properly supervise the conduct of its members, and the potential for rehabilitation.

C. Costs

88. Under s. 56(1) and (2) of the Act the Panel has broad discretion with respect to an order for costs. Section 56(1) of the Act permits the Panel to order all or part of the costs of the investigation and hearing. Section 56(2) of the Act expressly provides that costs include, among other things, the fees and expenses of investigators, payments made to members of the Panel, and costs incurred for the engagement of counsel for both the Complaints Committee and for the Panel.

89. The Panel accepts the submission, made by both parties, that an order for costs is not intended to be punitive. Instead, such an award is intended to distribute costs between the general membership of the College and the member whose misconduct has necessitated the investigation and hearing. The Panel also recognizes that costs should not be so prohibitive that they prevent members from defending themselves against professional discipline charges.

90. The Complaints Committee submitted that Mr. Pauch should contribute $75,000 to the College's costs, which would be approximately 30% of the actual and estimated costs of the College up to the date of the hearing.

91. The Complaints Committee relied on an affidavit from Dr. Brent Booker, the College's Assistant Registrar for Review and Resolution. Dr. Booker deposed that between October 2021 and February 2026, the College incurred legal costs in the amount of $137,558.45. These costs were incurred by the Complaints Committee in connection with Mr. Pauch's voluntary surrender of his pharmacist licence in October 2021, Mr. Pauch's appearances before the Complaints Committee on various occasions in 2021, 2022 and 2023, Mr. Pauch's non-compliance with drug and alcohol testing requirements, Mr. Pauch's request for reinstatement in 2023, preparation of Mr. Pauch's undertaking in July 2023, preparation of the notice of hearing, discussions with Mr. Pauch's counsel and preparation for the hearing.

92. Dr. Booker estimated that the Complaints Committee would incur further legal costs of $40,000 in March 2026, in connection with the hearing.

93. Dr. Booker also provided information about the costs incurred by the College's investigator. He deposed that the investigator spent 814 hours from the beginning of the investigation to March 10, 2025, at a cost of $64,809.75. Dr. Booker estimated that the investigator spent an additional 72 hours between March 10, 2025, and March 17, 2026, at an estimated cost of $3,890.

94. In total, Dr. Booker deposed that the actual and estimated costs incurred by the College in connection with Mr. Pauch's matter was $246,258.20. This total does not include the costs incurred by the College to engage counsel for the Panel, the payments to the members of the Panel, or the costs of the court reporter at the hearing. As discussed above, a panel of the Discipline Committee has discretion to include these latter items in a costs award under s.56(2) of the Act.

95. Mr. Pauch's submissions focused on *Charkhandeh v. College of Dental Surgeons of Alberta*, an Alberta Court of Appeal decision from 2025. In the Panel's view, *Charkandeh* is not consistent with the broadly discretionary language in the Act and, more generally, with the law in Manitoba relating to costs awards in professional disciplinary matters.

96. Though $75,000 is a significant amount of money, the Panel does not accept that a costs award in that amount would be a crushing financial burden on Mr. Pauch, especially since he will have five years to pay.

97. The Panel has considered the length and complexity of the investigation into Mr. Pauch's misconduct and the many steps at which the Complaints Committee required legal counsel to address Mr. Pauch's matter. The Panel finds that the costs described in Dr. Booker's affidavit were reasonable and proportionate to Mr. Pauch's misconduct. On this point, it is worth repeating that Mr. Pauch has pled guilty to several dozen Charges, involving 11 different patients, and at least 39,300 doses of unaccounted-for narcotic, controlled and targeted drugs. Approximately five years passed between the date of the initial complaint and the date of the hearing. It is unsurprising that the College incurred significant costs in these circumstances. The Panel rejects Mr. Pauch's submission that the Complaints Committee's approach to the investigation, the Charges, or the hearing unreasonably complicated the matter or unnecessarily increased the costs.

98. The Panel is satisfied that Mr. Pauch's own conduct prolonged and complicated the investigation and increased the College's costs. The Panel has found that Mr. Pauch lacked candour, was uncooperative and, at times, was deceptive in his dealings with the Complaints Committee and the College's investigator. It is therefore reasonable, proportionate and fair to require Mr. Pauch to contribute $75,000 to the College's costs. This is less than one-third of the total. `

99. Before concluding on this issue, the Panel wishes to specifically address the submission made by Mr. Pauch that an order for costs in the amount of $75,000 may discourage other pharmacists from being candid with the College about struggles with [redacted]. The Panel rejects this submission. In fact, had Mr. Pauch been truthful and candid with the College as and when he should have been, it is likely that the costs award would have been much less. In the Panel's view, the College's costs, and Mr. Pauch's proportionate share, are as high as they are not because of Mr. Pauch's candour and cooperation, but because of his failure to be candid and cooperative until late in the process.

VII. Conclusion

100. To summarize, pursuant to ss. 55 and 56 of the Act, the Panel orders that:

a. Mr. Pauch is suspended for 30 months, with credit of 28 months for the time during which Mr. Pauch was interim suspended between November 21, 2023 and March 21, 2026. For clarity, Mr. Pauch's suspension from practice ended May 20, 2026;

b. A fine of $25,000;

c. Restrictions on Mr. Pauch's practising licence for five years, to be effective from the date of his return to practice following the suspension that he will be prohibited from being a pharmacy manager or preceptor;

d. A requirement that Mr. Pauch complete, at his cost and with an unconditional pass, the PROBE Ethics course, by no later than March 31, 2027;

e. Mr. Pauch will enter into an undertaking with the College which will include terms related to the following:

i. He will complete a 360-hour internship before being permitted to return to practice, which is to be supervised by a preceptor approved by the College, and with bi-weekly reporting to the College;

ii. He will be limited to 35 hours per week of pharmacy practice in total across any pharmacies in which he may be employed, for a period of one year commencing upon the completion of his internship;

iii. Upon the completion of his internship, Mr. Pauch will be prohibited from the sole practice of pharmacy and cannot work in a pharmacy without another pharmacist present in the dispensary for a period of two months, immediately following which he will be prohibited from the sole practice of pharmacy without another person present for a subsequent six months;

iv. The pharmacy manager in any pharmacy in which Mr. Pauch is employed shall provide reporting to the College on the following basis:

1. Monthly, for a period of three months following completion of the internship; and

2. Quarterly, for the following nine months;

v. Unless approved in advance in writing by the College, or in emergency situations where prescribed and the College is promptly notified, Mr. Pauch will abstain from consuming any controlled drugs for a period of two years;

vi. At Mr. Pauch's cost, he will submit to up to 12 random drug and alcohol screenings annually, for a period of two years, which shall be at the direction of the College and/or CBI Health and of which, four samples annually will be hair samples;

vii. He will participate in monthly in-person counselling sessions with a qualified therapist and/or addictions counsellor, with reporting to the College on a monthly basis, for a period of one year;

viii. He will be required to advise the pharmacy manager in all pharmacies which employ him that monthly reconciliation counts of narcotics, controlled drugs, and targeted drugs must occur; and

ix. He will be required to advise the pharmacy manager in all pharmacies which employ him of the restrictions on his licence.

f. Mr. Pauch is ordered to pay a contribution toward the costs of the investigation and hearing in the amount of $75,000.00.

g. Mr. Pauch will have five years from the date of this decision to pay the fine and contribution to costs ordered in subparagraphs (b) and (f), respectively.

h. There will be publication of the conviction, penalty and circumstances of the offences, including publication of Mr. Pauch's name.

DATED at Winnipeg, Manitoba, this 9th day of June, 2026.

THE COLLEGE OF PHARMACISTS OF MANITOBA



Per: Martha Mikulak
Chair, Discipline Panel