Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 14/12/2018 - 20/12/2018

Medical Practitioner's name: Dr Julian MANIESON

GMC reference number: 5204914

Primary medical qualification: MB ChB 1997 University of Ghana

Type of case
New - Misconduct

Outcome on impairment
Impaired

Summary of outcome
Suspension, 1 month.

Tribunal:

Legally Qualified Chair	Mr Richard Tutt
Lay Tribunal Member:	Dr Kevin Hope
Medical Tribunal Member:	Dr Karen Slade

Tribunal Clerk:	Mr Sean Connor

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Ms Charlotte Mitchell-Dunn , Counsel, instructed by Kingsley Napley LLP
GMC Representative:	Ms Emma Gilsenan, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held partly in public and partly in private.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts and Impairment - 18/12/2018

Background

1. Dr Manieson qualified in Ghana in 1997 and at the time of the events Dr Manieson was practising as a Specialty doctor at Ashford and St Peter's Hospitals NHS Foundation Trust in Surrey.

2. Between 12 January 2017 and 3 July 2017, Dr Manieson presented over thirty private prescriptions to Asda Pharmacy in Watford. The prescriptions were written in the names of multiple patients and were signed by Dr Manieson.

3. Ms A a Pharmacy Manager observed that Dr Manieson was writing an increasing number of private prescriptions. Ms A stated that she was informed by a colleague that Dr Manieson was prescribing medication for patients overseas. Ms A became concerned with the frequency of private prescriptions and noted that the same address on a number of the prescriptions was being used for a number of different patients. Ms A reported her concerns to the GMC on 3 July 2017 and forwarded a batch of the prescriptions.

The Allegation and the Doctor's Response

4. The Allegation made against Dr Manieson is as follows:
That being registered under the Medical Act 1983 (as amended):

> 1. Between 12 January 2017 and 3 July 2017 you presented private prescriptions on behalf of several alleged patients ('the Prescriptions') to the pharmacy at Asda Stores Ltd, XXX ('Asda Pharmacy'), as set out in Schedule 1.
> **Admitted and found proved**
>
> 2. The address set out in Schedule 2 is your business address and was used on 22 of the Prescriptions.
> **Admitted and found proved**
>
> 3. The address set out in Schedule 3 is your home address and was used on seven of the Prescriptions.

Admitted and found proved

4. You presented the Prescriptions to Asda Pharmacy despite:

a. the named patients not being your patients;
Admitted and found proved

b. failing to:

(i) carry out consultations with some, or all, of the named patients;
Admitted and found proved

(ii) undertake a proper assessment of some, or all, of the named patients' medical histories;
Admitted and found proved

(iii) consider and/or advise some, or all, of the named patients about the impact of the medicines you were prescribing to them.
Admitted and found proved

The Admitted Facts

5. At the outset of these proceedings, through his counsel, Ms Mitchell-Dunn, Dr Manieson made admissions to all of the paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

The Tribunal's Determination on Impairment

6. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Manieson's fitness to practise is impaired by reason of misconduct.

Witness Evidence

7. The Tribunal also received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- Ms A, Pharmacist Manager (the pharmacist)
- Ms B, Registration Information Manager

8. Dr Manieson provided his own witness statement dated 14 December 2018. In addition Dr Manieson provided three responses to the Allegation to the GMC, dated 10 and 11 September 2017 and 5 March 2018. The Tribunal were also provided with a note of a telephone conversation between Dr Manieson and the GMC dated 20 July 2017.

9. The Tribunal also received evidence on behalf of Dr Manieson in the form of a witness statement from Dr E, Dr Manieson's Responsible Officer who was not called to give oral evidence.

Documentary Evidence

10. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included, but was not limited to:

- Referral form for the GMC: Fitness to Practise for Further Investigation form
- Copies of handwritten private prescriptions
- Letter from the GMC to Dr Manieson enclosing copy of updated contact details
- Address search result from 192.com regarding Mr C
- Companies House search result regarding Mr D
- The GMC's guidance 'Good practice in prescribing and managing medicines and devices' dated March 2013
- Telephone note dated 20 July 2017 between Dr Manieson and the GMC
- Emails dated 10 and 11 September 2017 and 5 March 2018 from Dr Manieson to the GMC
- Medicines, Ethics and Practice – The professional guide for pharmacists dated July 2016
- Certificate of Attendance and report from XXX Training dated 27 November 2018
- Testimonial letter dated 14 December 2018 from Dr F, Consultant in Emergency Medicine, Clinical Lead Emergency Department, St Peter's Hospital

Submissions

11. On behalf of the GMC, Ms Gilsenan submitted that Dr Manieson prescribed over 30 private prescriptions between 12/01/17 – 03/07/17. Ms Gilsenan stated that although the prescriptions were not controlled drugs or drugs of abuse, there was a pattern of prescribing by Dr Manieson for a number of patients for more than six months.

12. Ms Gilsenan told the Tribunal the alleged patients Dr Manieson prescribed for were overseas and as such he had not conducted proper assessments of the patients and had offered no advice on the impact of the prescribed medication. Further, she submitted that there was no evidence that the prescriptions were for

genuine patients. Ms Gilsenan referred to paragraph 16 of the GMC's guidance Good Medical Practice (GMP) 2013, which states:

> *'16. In providing clinical care you must:*
>
> *a. prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs*
>
> *f. check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving, including (where possible) self-prescribed over-the-counter medications.'*

13. Ms Gilsenan referred the Tribunal to paragraphs 14, 21, 23 and 37 of the Guidance "Good practice in prescribing and managing medicines and devices":

> *'14. You should prescribe medicines only if you have adequate knowledge of the patient's health and you are satisfied that they serve the patient's needs.*
>
> *21. Together with the patient, you should make an assessment of their condition before deciding to prescribe a medicine. You must have or take an adequate history, including:*
>
> *a. any previous adverse reactions to medicines*
>
> *b. recent use of other medicines, including non-prescription and herbal medicines, illegal drugs and medicines purchased online, and*
>
> *c. other medical conditions.*
>
> *23. You should identify the likely cause of the patient's condition and which treatments are likely to be of overall benefit to them.*
>
> *37. If you prescribe at the recommendation of another doctor, nurse or other healthcare professional, you must satisfy yourself that the prescription is needed, appropriate for the patient and within the limits of your competence.*

14. Ms Gilsenan submitted that although Dr Manieson had provided an apology to the GMC, he had shown no insight into his failings and appeared to suggest that he had done nothing wrong. She said that there was little evidence that Dr Manieson would not repeat this pattern of behaviour. Dr Manieson had not provided any evidence of who needed the life-saving medication. Ms Gilsenan asked the Tribunal

to note that there was a lack of documentary evidence from Dr Manieson such as emails or WhatsApp messages in relation to the colleagues and patients. Further, that Dr Manieson had not provided any bank statements for payment by the patients for the medication. Ms Gilsenan stated that Dr Manieson had not fully explained why he provided the patients with medication. Dr Manieson had not provided an explanation as to what relationship, if any, he has to XXX Limited or Mr D who is the registered director. Dr Manieson had not explained why on the batch of prescriptions provided he had also used a third and fourth address over and above his two addresses.

15. Ms Gilsenan submitted that had Dr Manieson followed GMP he would not have prescribed to the patients in the manner in which he did. Ms Gilsenan submitted that the public would be surprised at the manner in which Dr Manieson had prescribed medications without arranging an assessment or providing advice on the impact of the medication. Ms Gilsenan stated that Dr Manieson's pattern of behaviour fell short of the expected standards of a doctor. Further, she submitted that Dr Manieson's actions amounted to serious misconduct and that his fitness to practise is currently impaired by reason of that misconduct. She submitted a finding of impairment was required to ensure public confidence was not undermined and to uphold proper standards.

16. On behalf of Dr Manieson, Ms Mitchell-Dunn accepted that the actions of Dr Manieson fell below the standards that he was supposed to uphold. Further, she stated that Dr Manieson accepts he is currently impaired on public interest grounds. Ms Mitchell-Dunn told the Tribunal that Dr Manieson has sought to remedy his actions. She referred the Tribunal to the certificate and report from Dr G according to which Dr Manieson freely admitted his wrong doing and demonstrated insight. She stated that Dr Manieson regrets his behaviour and letting the profession down. Dr Manieson now knows not to deviate from correct prescribing.

17. Ms Mitchell-Dunn stated that Dr Manieson has had no conditions on his practice to date and there have been no other issues in relation to prescriptions.

18. Ms Mitchell-Dunn submitted that the prescriptions were for chronic conditions, and were not controlled drugs. She stated that there is no evidence to suggest there was any dishonesty from Dr Manieson or that he abused his position; indeed that was not the GMC's case as set out by the Allegation. She stated that Dr Manieson had been transparent in that he provided his GMC registered addresses on the prescriptions and the names of the individuals he was prescribing for.

19. Ms Mitchell-Dunn told the Tribunal that Dr Manieson has fully accepted the allegation and accepts misconduct and impairment and on that basis there was no requirement for him to provide any evidence. Further, she submitted that it is for the GMC to prove its case against Dr Manieson. Dr Manieson had been nothing other than open and transparent. He had not been dishonest. Dr Manieson had informed

Ms A's colleague that he was prescribing for patients who resided overseas. She stated that Dr Manieson accepts that his actions were misguided. Further, she stated that Dr Manieson recognises that he has put individuals at risk and breached the standards required of him.

20. Ms Mitchell-Dunn submitted that Dr Manieson was prescribing private prescriptions, which he paid for and there had been no abuse of the NHS system. Dr Manieson has apologised for his actions and the evidence from Dr G shows that he has taken genuine steps towards remediation and demonstrated insight.

The Tribunal's Approach

21. The Tribunal noted the GMC's submissions in relation to the following:

- Whether or not the prescriptions Dr Manieson wrote were for genuine patients
- Whether Dr Manieson had any business interest in 'XXX Limited'
- The significance of the two additional addresses, (other than Dr Manieson's two known GMC registered addresses)
- Whether Dr Manieson followed the correct procedure or required a licence to export medicines overseas
- The absence of banking documentation confirming that Dr Manieson was paid by the overseas patients for the medicines
- The absence of email or 'WhatsApp' exchanges between Dr Manieson and professional colleagues or patients overseas

22. The Tribunal noted paragraph 1 of the Allegation refers to 'several alleged patients'. However, the Tribunal was mindful that there is no allegation of dishonesty, which would be a very serious matter. The Tribunal could only consider the case against Dr Manieson on the Allegation and the evidence put before it.

23. The Tribunal was provided with 31 prescriptions dated between 12 January 2017 and 3 July 2017. The Tribunal noted that the pharmacist, Ms A stated the following:

> *'…I provided the GMC with a batch of prescriptions, via fax, and I later faxed some further prescriptions to the GMC on 19 July 2017 and 20 July 2017. I can't remember the time period that the prescriptions cover. There were plenty more prescriptions, I just provided one batch that I found.'*

24. The Tribunal noted that Ms A referred to "plenty more" than the 31 prescriptions. The Tribunal noted that Dr Manieson mentioned in his emails to the GMC that he had been prescribing for overseas patients for approximately one year. However, the Tribunal only had 31 prescriptions and was cautious to draw any inferences from them save that this was an established pattern of behaviour.

25. The Tribunal noted that there were 22 prescriptions in Schedule 1 (numbers 1-7, 11- 17, 19, 20, 24-27, 29 and 31) for Dr Manieson's GMC registered address from 18 May 2012. There were 7 prescriptions in Schedule 1 (numbers 8, 9, 18, 21-23 and 28) for Dr Manieson's GMC registered address from 2006 to 2012.There was one prescription in the name of Mr C with a third address listed on Schedule 1 (number 10) and one prescription in the name of Mr D with a fourth address listed on Schedule 1 (number 30).

26. The Tribunal received no further information about the link between Dr Manieson and Mr D. The Tribunal was not provided with any evidence that Dr Manieson had any link with 'XXX Limited'.

27. The Tribunal noted the GMC submissions went beyond the Allegation as set out above. The Tribunal also noted that Ms Gilsenan appeared to suggest a reverse burden of proof on Dr Manieson in relation to the facts.

28. The Tribunal noted Ms A's statement in relation to the types of drugs prescribed by Dr Manieson on the private prescriptions, as follows:

> *'The actual drugs listed on the prescriptions were not concerning to me as They were everyday drugs, like diabetic drugs or blood pressure drugs, not controlled drugs or drugs of abuse.'*

29. The Tribunal was satisfied that the drugs prescribed by Dr Manieson were not controlled drugs. However, the Tribunal was not provided with any evidence by the GMC relating to the procedure required to export medicines overseas.

30. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision on impairment is a matter for the Tribunal's judgement alone.

The Relevant Legal Principles

31. In approaching its decision, the Tribunal was mindful it is required to determine whether, in the light of the facts admitted and found proved, Dr Manieson's fitness to practise is impaired by reason of misconduct. The Tribunal has borne in mind that consideration of impairment by misconduct involves a two-stage process; firstly, the Tribunal must determine whether the facts found proved amount to misconduct, and that the misconduct was serious; and secondly, whether as a result, Dr Manieson's fitness to practise is thereby impaired.

32. The Tribunal must determine whether Dr Manieson's fitness to practise is impaired today, taking into account his conduct at the time of the events and any relevant factors

since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

Misconduct

33. The Tribunal noted paragraphs 16a and 16f of the GMC's guidance GMP (2013) as set out above.

34. The Tribunal also noted paragraphs 14, 21, 23 and 37 of the GMC's guidance 'Good practice in prescribing and managing medicines and devices' dated March 2013, as set out above.

35. The Tribunal considered that in writing prescriptions, including repeat prescriptions, for overseas patients, whom he had not undertaken a consultation with Dr Manieson did not have adequate knowledge of the patients' health and could not have been satisfied that the drugs or treatment served the patients' needs. The Tribunal also considered that Dr Manieson had not checked that the care or treatment he provided for each patient was compatible with any other treatments the patient was receiving, including self-prescribed over-the-counter medications. The Tribunal received no evidence that Dr Manieson took an adequate history, including any previous adverse reactions or recent use of other medicines, non-prescription and herbal medicines, illegal drugs and medicines purchased online or any other medical conditions.

36. The Tribunal considered that Dr Manieson has breached the principles in 'GMP' and 'Good practice in prescribing and managing medicines and devices' and in doing so put patients at risk of harm. The Tribunal also considered that Dr Manieson's actions undermined public confidence in the profession as the public would be concerned by a doctor not adhering to the prescribing guidance issued by his regulator.

37. The Tribunal determined that Dr Manieson's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amounts to serious misconduct.

Impairment

38. The Tribunal having found the facts proved amounted to misconduct went on to consider whether, as a result of that misconduct, Dr Manieson's fitness to practise is currently impaired.

39. The Tribunal has borne in mind the statutory overarching objective, which includes to:

(a) protect, promote and maintain the health, safety and well-being of the public

(b) promote and maintain public confidence in the medical profession

(c) promote and maintain proper professional standards and conduct for members of the medical profession.

Dr Manieson's response in July 2017

40. The Tribunal took account of the note of a telephone conversation between Dr Manieson and the GMC, dated 20 July 2017, in response to the GMC's initial disclosure letter. It was recorded that Dr Manieson stated that in writing the prescriptions he was trying to help patients abroad. He said that he was contacted by colleagues abroad to request urgent medication. He stated that the medication in Ghana could not be trusted as fake medications were prevalent there.

41. Dr Manieson said that he would write the prescriptions and send them to the patients urgently by courier. Dr Manieson stated that he had taken prescriptions for foreign patients to pharmacies who advised they could not be dispensed because of the foreign addresses. He said that he checked the Pharmacy guidelines and thought he could use private prescriptions for these patients instead. Dr Manieson said he was very cautious and thought he was directly following the guidelines. Dr Manieson confirmed that he paid for the prescriptions himself and the patients refunded him the money. He said that he did this because of the urgent need for the medication. Dr Manieson stressed he was trying to help people and confirmed that he would not prescribe in this way again.

Dr Manieson's written responses dated 10 and 11 September 2017

42. Dr Manieson stated that over the years there has been a need for critical medicines abroad and that some individuals who are on regular medication can no longer rely on medicines because they are fake. He stated that these medications are seriously endangering lives and that some medicines are not available despite being critical. He stated the cost of prescriptions abroad can be phenomenal for what can be fake medicine.

43. Dr Manieson stated that he decided to help patients overseas and felt an obligation to them as it was their taxes that put him through medical school. He went on to say none of these prescriptions cost the NHS and he had not gained financially. He stated that the prescriptions met the guidelines referred to in 'The Royal Pharmaceutical Society- Medicines, Ethics and Practice', July 2016 edition in that they contained all the relevant details.

44. Dr Manieson stated that he had explained to the senior pharmacist that the patients were abroad and lived in developing countries like Ghana. He said that the patients' residential addresses in Ghana were completely unreliable. He said that he could contact the patients by international calls if there was a problem with the prescriptions in the same way that UK doctors do. He stated that the pharmacies had accepted and dispensed the medicines using this arrangement for over a year, both for regular repeat prescriptions and 'urgent lifesaving medicines'. He stated that these were the reasons that he used his own addresses on the prescriptions. He stated that the address listed in Schedule 1 (numbers 1-7, 11- 17, 19, 20, 24-27, 29 and 31) was his current GMC registered address and the address listed in Schedule 1 (numbers 1-7, 11- 17, 19 and 20) was his previous GMC registered address which he used for study and as a private office. Dr Manieson stated if he prescribed for a colleague who had a UK address he used their UK address, such as his colleague Mr D.

45. Dr Manieson stated that he had used the period (since July 2017) to study more about prescriptions both from the Medicines, Ethics and Practice, Professional guide for pharmacists and GMP sections on prescriptions. He stated that a senior pharmacist had also taken him through prescriptions and the safe transfer of medicines abroad. He also stated that he was looking forward to taking modules in medicines to help with his education and personal development.

46. Dr Manieson expressed regret and assured the GMC he had learned valuable lessons to ensure safe practice and patient safety.

47. The Tribunal noted that it was submitted on Dr Manieson's behalf that there was transparency as both of the addresses in Schedule 1 (numbers 8, 9, 18, 21-23, 28 and 1-7, 11- 17, 19, 20, 24-27, 29 and 31) were his GMC registered addresses.

48. The Tribunal noted Dr Manieson's written responses dated 5 March 2018:

> *…….*
> *1. Foremost the medicines are very expensive. I communicate with the individuals and their doctor before rewriting their overseas prescription and paying for them. Also need to arrange for them to pay me back. It's highly unlikely that I wouldn't find out their medical background. What if they don't need these medicines or the doctors have made changes to the prescriptions. All this at no profit.*
>
> *2. To the very best of my knowledge, none of these patients on repeat prescriptions have complained about not being adequately reviewed before getting their prescriptions. Above all I have not seen any evidence from the investigation of any patient not being adequately assessed by myself.*

3. I have followed the Good medical practice guidelines and that of the Royal pharmaceutical society. The only issue was the address. To which I used my address. The reason, if there is a problem, it will be easier to get me to contact the clients than the pharmacist at ASDA to contact someone in the middle of West Africa.

4. It will be hard for anyone in the medical profession to examine the overseas prescription and mine. And make a conclusion of bringing the profession to disrepute. It ticks all the boxes of Good medical practice .The difference is the address I have explained above.

5. The patients repeat prescriptions, medical history and their conditions have not only been seen to by only one doctor but two. Myself being the second. Hence the medical history of the individuals are well known.

6. This investigation is probably not common. It is most relevant to Good medical prescribing and managing devices, paragraph 37. ie If you prescribe at the recommendation of another doctor or nurse or other health care professional, you must satisfy yourself that the prescription is needed, appropriate for the patient and within the limits of your competence.

I have seriously without any doubt taken this into account together with the general measures of prescribing under Good medical practice.

7. I have not been to Ghana in West Africa for over 14 years. But i have been twice in the last 2 years. Part of the reasons to see and verify both the individuals on repeat prescriptions, their medical information and their doctors.

8. Why i provided this assistance to patients abroad. The WHO recognise that over 100000 people in Africa die from counterfeit medicines. According to the Lancet in 2012 detection of fake medicines are increasingly becoming difficult. Some even add active ingredients to pass quality control. But not enough to provide the user any benefits. Hence people are seriously looking for access to get genuine medicines. Therefore my small way of providing a non profitable access and help.

9. I would be happy to bring witnesses involved from abroad if it will help my case in anyway. Am very happy to go through again any recognised course regarding prescriptions. I will also take modules to reassure you that I take this very seriously and to further help my practice. Am open to any other recommendations.

10. I have been through a lot, both psychologically and physically with this investigation. Please I don't think I deserve anything to put a BLOT on my

registration and practice. I have done everything possible and to a very large extent to make sure I have followed every letter as stipulated by our Good Medical Practice.

11. I would be glad if you consider the above in your judgement.

12. These overseas private prescriptions have not been at any cost to the NHS in general and no NHS prescriptions have been used.'

49. The Tribunal noted Dr Manieson's Witness Statement dated 14 December 2018. In which he stated that he qualified in Ghana in 1997 and came to United Kingdom in 2000. He obtained full registration with the GMC in 2004 and has been working in the UK for 14 years. He is currently working as a Specialty doctor in A&E and has been doing that for some years.

50. Dr Manieson stated that he did not seek to shirk his responsibilities, or diminish the seriousness of his actions, he stated he would like to provide the Tribunal with some context. He stated that either the patient or their doctor would contact him. He would then be sent the prescription through a picture on Whatsapp so that he knew which medication the patient required. He stated that he would correspond with the patient via telephone or Whatsapp, unless the request came directly from their doctor. He stated that he accepts that as a minimum he should have spoken to the patients in all cases. He stated that when he corresponded with the patient, he would conduct a brief assessment by asking them about their condition and the medication, such as how long they had been taking it and whether they had experienced any side-effects. He accepted that the assessments were not of the standard that he would have conducted had he had better access to the patient.

51. Dr Manieson stated that he would then write a private prescription using one of his two addresses and present it to the pharmacy. He also accepted that was a complete error of judgement on his part and that he should have used the patient's address regardless of where they lived.

52. Dr Manieson confirmed that he paid for all of the prescriptions at commercial value. He stated that at no point did he abuse the NHS system to provide the medication to the patients. Dr Manieson explained his two GMC registered addresses.

53. Dr Manieson sincerely apologised for his actions. He stated that he had had a lot of time to reflect, and understood entirely why the GMC had referred this case to a hearing. He stated that as a doctor, with a license to practise, he has a duty to ensure that he acts in a manner which is congruent with his registration and in which the profession and the public alike would expect.

54. Dr Manieson confirmed he has refreshed his knowledge of GMP and that he now knows that he must endeavour always to provide a good standard of practice and care. Dr Manieson referred to the specific paragraphs of GMP he has have focussed on.

55. Dr Manieson stated that whilst at the time he was seeking to act in the best interests of the patients by ensuring that they obtained reputable and safe medication, he now realises that as he did not have a professional relationship with the patient whereby he had fully assessed them, taking into account their full medical history and individual presentation, he did not practise within the ambits expected of him. He stated that he was truly sorry, and gave assurances that he will not act in such a manner again.

56. Dr Manieson stated that on 18 and 25 November 2018 he had undertaken sessions with Dr G and provided a certificate of attendance and report. He stated that he had shared the GMC's bundle with Dr G. He stated that they had a full and frank discussion about the circumstances leading to his case. Dr Manieson reiterated that he was genuinely sorry for his behaviour and that he appreciated that he will have to continue to rebuild the trust of those around him including his regulator and that he was committed to doing so. He stated that this process in itself has been a steep learning curve but has confirmed the importance of practising within the boundaries expected of a registered doctor. He confirmed that this was his first fitness to practise complaint.

57. The Tribunal noted the certificate of attendance for XXX Training dated 27 November 2018. It also noted the report from Dr G dated 14 October 2018, which states:

> *'I have had two one-hour phone sessions with Dr Manieson (November 18th and 25th 2018). He is due to appear before a MPTS on December 10th 2018; I have seen his GMC bundle.*
>
> *During these sessions, Dr Manieson freely admitted his wrongdoing. Although the medication had been prescribed by a clinician in Ghana, he personally had not met, examined the patients involved or made them aware of any issues that may have arisen as a result of the medication prescribed.*
>
> *He demonstrated insight into how vulnerable this arrangement was for the patients involved, being able to describe the possible dangers to which his actions exposed them.*
>
> *We discussed the role of the GMC in protecting patients and maintaining trust in the profession. He expressed regret that his behaviour fell well below the standards expected of doctors, letting himself and the profession down so badly.*

I understand he made no financial gain from his actions, the prescriptions written were private and were for chronic medical conditions. He told me that he immediately stopped his activities when the initial complaint was made and, despite further requests from Ghana, has refused any further remote prescribing.

He works in A&E and was able to describe the boundaries of his prescribing practice in this clinical setting. My belief is that he now knows not to deviate from those strict limits.

Should the GMC impose conditions or a period of suspension, I would be happy to provide further mentoring and support.'

58. The Tribunal noted the testimonial letter dated 14 December 2018 from Dr F, Clinical Lead Emergency Department, St Peter's Hospitals NHS Foundation Trust. Dr F stated that Dr Manieson is a valuable member of the team. He confirmed that he was aware of the allegations against Dr Manieson and confirmed that Dr Manieson has a lot of experience in Emergency Medicine. He stated that Dr Manieson is honest in his work and works with integrity. He stated that there have been no probity issues and that Dr Manieson has always remained trustworthy.

59. The Tribunal noted the witness statement from Dr Manieson's Responsible Officer, Dr E, dated 7 December 2018. E confirmed that he was aware that the allegation related to repeated and unusual patterns of prescribing. Dr Manieson had informed him that he had been prescribing overseas as he was concerned about the quality of the medication that was available locally. He stated that Dr Manieson assured him that he had been paying for the medication and not prescribing it via the NHS and the Trust had not identified anything to suggest otherwise. Dr Manieson had assured him that he had stopped the prescribing behaviour and had discussed this matter in his appraisal. Dr Manieson was apologetic and contrite.

60. Of particular significance to the Tribunal was the report from Dr G stating that Dr Manieson freely admitted wrongdoing and demonstrated insight into how his prescribing may have affected patients involved. Dr G also stated that Dr Manieson expressed regret that his behaviour fell short of the standards expected. The Tribunal noted that Dr G believes that Dr Manieson now knows not to deviate from these strict limits.

61. The Tribunal noted that Dr Manieson had immediately stopped these activities and despite further requests for overseas prescriptions has refused to continue any "remote prescribing." The Tribunal noted that working in A&E Dr Manieson has been prescribing within the correct boundaries.

62. The Tribunal was satisfied that Dr Manieson had provided evidence of remediation which demonstrates that he is developing insight, such that he was not liable to repeat his misconduct.

63. The Tribunal was conscious that it has a duty to uphold all three limbs of the statutory overarching objective contained within the Medical Act:

(a) to protect, promote and maintain the health, safety and well-being of the public,
(b) to promote and maintain public confidence in the medical profession, and
(c) to promote and maintain proper professional standards and conduct for members of the medical profession.

64. The Tribunal determined that, in the light of its finding that Dr Manieson is not liable to repeat his misconduct, limb (a) of the statutory overarching objective is satisfied.

65. However, the Tribunal has borne in mind the public interest in this case and that the public rightly expects doctors to follow the guidance issued by their regulator. The Tribunal concluded that public confidence in the profession would be undermined, as would the promotion and maintenance of proper professional standards and conduct, if a finding of impairment were not made.

66. The Tribunal has therefore determined that Dr Manieson's fitness to practise is impaired by reason of his misconduct.

Determination on Sanction - 20/12/2018

1. Having determined that Dr Manieson's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose. The Tribunal has borne in mind the Sanctions Guidance (February 2018) (the SG).

The Evidence

2. The Tribunal received further evidence on behalf of Dr Manieson including:

- Oral evidence from Dr Manieson
- Testimonial in support of Dr Manieson from Dr H, Consultant in Emergency Medicine, Ashford and St Peter's Hospitals NHS Foundation Trust
- The figures for the number of patients Dr Manieson has treated at Ashford and St Peter's Hospitals NHS Foundation Trust

Dr Manieson's oral evidence

3. Dr Manieson told the Tribunal of his educational background and how he came to work in the UK. Dr Manieson told the Tribunal that he is due to revalidate next year. He explained that he is up to date with all mandatory training at his Trust. He stated that he works in front-line emergency medicine which is a high risk area but that he is fully supported at work. He confirmed that he has had no previous fitness to practise concerns.

4. Dr Manieson told the Tribunal that he admitted the Allegation as he wrote all of the prescriptions. He said that he deeply regretted writing the prescriptions and he should have sought more information regarding prescribing to ensure he was following the correct guidance. He told the Tribunal that he has discussed the Allegation informally with his colleagues over the past year and a half. He told the Tribunal that initially he was not fully conversant with GMP and GMC's guidance *'Good practice in prescribing and managing medicines and devices'* but went through the guidance with Dr G. He stated that he realised that his knowledge had been lacking in this area. He apologised and said that he realised how far short he had fallen in terms of the overseas prescriptions.

5. He stated that he is now fully aware that when he writes a prescription, even if it is a repeat prescription, it is his responsibility to ensure it is done in accordance with the guidelines. He stated that before writing any prescription he should take a full patient history, including medications and reactions.

6. Dr Manieson stated since the Allegation he has joined the Department's Prescription Board, which catalogues any prescribing mistakes made at St Peter's Hospitals NHS Foundation Trust. Additionally, he stated that the Trust has recently introduced a new prescription format which has not yet been audited and that he will be presenting the audit at the next quarterly meeting of the Board.

7. Dr Manieson told the Tribunal that Dr H is an A&E Consultant who supervises him at St Peter's Hospital. He stated that in the A&E department they work as a team and he has been given a great amount of support. He stated that if the Tribunal determined to impose conditions on his practice he would be able to continue working at St Peter's Hospital and would be covering the night shift. He stated that he had made a mistake; there have been no concerns raised about his prescribing since the Allegation arose.

8. In relation to GMP, Dr Manieson told the Tribunal that a doctor must have adequate knowledge of the patient before prescribing and reiterated that he was sorry that he did not have that knowledge when he wrote the prescriptions for the overseas patients. He assured the Tribunal that this would never happen again.

9. Dr Manieson acknowledged that he had not complied with paragraphs 16a or 16f of GMP, neither had he complied with paragraphs 14, 21, 23 or 37 in '*Good practice in prescribing and managing medicines and devices guidance',* as previously set out at paragraphs 12 to 13 of the impairment determination.

10. Dr Manieson accepted that his initial responses to the GMC were inadequate. He said that it was a complete disgrace and unacceptable that he had not followed the guidance; he was embarrassed. He acknowledged that they were very serious mistakes and again stated that he was very sorry. He stated that had he followed the guidance he would not have prescribed at all as these were not his patients.

11. Dr Manieson told the Tribunal that he had informally discussed the GMC's investigation with his Consultant colleagues. He said that he had first discussed the Allegation with his solicitor in July/August 2018; before which he had been confused. He undertook his first formal retraining/remediation with Dr G in November 2018. He said that this work was extremely helpful and crystallized his understanding of his misconduct. Dr Manieson indicated that he would like to undertake further training with Dr G in the future.

12. In relation to the GMC's guidance on prescribing Dr Manieson told the Tribunal that he had been studying the guidance since the Allegation arose. He stated that he had also refreshed his knowledge of the introductory chapter of British National Formulary (BNF). Dr Manieson told the Tribunal that colleagues have, on occasion, asked him to prescribe antibiotics on an ad hoc basis but he now refuses to write prescriptions for colleagues. Dr Manieson told the Tribunal that he discussed the Allegation with Dr F at his appraisal last year when he was aware of the investigation and also at his most recent appraisal in November 2018.

13. Dr Manieson stated that he recognised his misconduct has affected the public interest. He said that he is still receiving requests from overseas doctors to prescribe but explained that he no longer prescribes for overseas patients and has no intention of doing so in the future. He said that those he previously prescribed for understand and are sympathetic to his position.

Ms Gilsenan's Submissions

14. On behalf of the GMC, Ms Gilsenan referred the Tribunal to the SG and reminded it of the overarching objective. Amongst others, she referred the Tribunal to the following paragraph of the SG:

> *'20. In deciding what sanction, if any, to impose the tribunal should consider the sanctions available, starting with the least restrictive. It should also have regard to the principle of proportionality, weighing the interests of the public against those of the doctor (this will usually be an impact on the doctor's career, eg a short suspension for a doctor in training may significantly disrupt*

> *the progression of their career due to the nature of training contracts). In relation to aggravating and mitigating factors.'*

15. She acknowledged that Dr Manieson has no previous fitness to practise findings against him. However, she stated that his actions represented a pattern of prescribing.

16. She stated that Dr Manieson had cooperated with the investigation. However, she stated it was clear, even in March 2018, breaches of guidance were not accepted by Dr Manieson, which was contrary to his position today. Ms Gilsenan submitted this was relevant to insight and demonstrated that Dr Manieson did not have full insight until this hearing.

17. Ms Gilsenan reminded the Tribunal that there has been an absence of evidence from Dr Manieson in relation to the facts and she reiterated the submissions summarised at paragraph 21 of the impairment determination. Ms Gilsenan suggested it was entirely a matter for the Tribunal how this absence of evidence affected its assessment of Dr Manieson's credibility.

18. Ms Gilsenan submitted that there was limited evidence of remediation. However, she acknowledged that in his most recent witness statement Dr Manieson accepted he had breached GMC guidance.

19. Ms Gilsenan stated that Dr Manieson has not provided a broad spectrum of testimonials from colleagues. He had not completed courses or online learning in relation to prescribing. She acknowledged Dr Manieson had apologised but suggested this had come late in the day and could be seen as self-serving. In relation to insight, Ms Gilsenan stated that Dr Manieson's full admissions demonstrated some insight.

20. Ms Gilsenan submitted that it would not be appropriate to take no action in light of the Tribunal's findings on impairment, as this was not an exceptional case. She stated that the seriousness of the pattern of prescribing warranted a sanction.

21. In light of the Tribunal's findings on impairment, the seriousness of the misconduct and the public interest, Ms Gilsenan submitted that conditions would not be appropriate or proportionate. She submitted that Dr Manieson's misconduct necessitated an order of suspension.

22. Ms Gilsenan referred the Tribunal to paragraph 91 of the SG, which states:

> *'91. Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from*

earning a living as a doctor) during the suspension, although this is not its intention.'

23. Ms Gilsenan stated there had been a serious departure from GMC guidance and there was a need to satisfy the overarching objective. Ms Gilsenan submitted that suspension was proportionate and in the public interest. She made no submissions as to length of suspension.

Ms Mitchell- Dunn's Submissions

24. On behalf of Dr Manieson, Ms Mitchell-Dunn submitted that he had admitted the Allegation in full and accepted misconduct and impairment at the outset of the hearing. She stated that he understands the need to uphold public confidence in the profession and she referred the Tribunal to his insight into what his colleagues and the public would think. She stated that Dr Manieson is a man of good character with no previous fitness to practise findings against him. Ms Mitchell- Dunn submitted that, given Dr Manieson's insight and remediation, the Tribunal should impose an order of conditions.

25. Ms Mitchell-Dunn reminded the Tribunal that Dr Manieson had made a sincere apology which was reflected in the testimonial letters from his colleagues. She referred the Tribunal to Dr G's report in relation to Dr Manieson's remediation. She confirmed that Dr Manieson would not prescribe for overseas patients in the future. She submitted that Dr Manieson had corrected his behaviour and undertaken clear steps to remedy his deficiencies.

26. Ms Mitchell-Dunn referred the Tribunal to the references provided and to the statement of Dr Manieson's Responsible Officer, Dr E.

27. Ms Mitchell-Dunn stated that Dr Manieson was misguided in his attempt to assist patients overseas where he knew there were serious issues with medication. She reminded the Tribunal that these matters occurred in 2017 and there have been no concerns with Dr Manieson's prescribing since.

28. Ms Mitchell-Dunn referred the Tribunal to paragraph 82 of the SG which states:

'82. Conditions are likely to be workable where:

a. the doctor has insight

b. a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings

c. the tribunal is satisfied the doctor will comply with them

> *d. the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised.'*

29. Ms Mitchell-Dunn stated that Dr Manieson has insight, is willing to respond to re-training, has confirmed that he will comply with any conditions imposed and has the potential to respond positively to remediation, or retraining. She stated that Dr Manieson had been open and honest about his failings and the GMC were seeking to go behind the Allegation in questioning Dr Manieson's credibility. She submitted that whilst there was serious misconduct in this case, it was not so serious that it warranted suspension of his registration. Ms Mitchell-Dunn provided the Tribunal with a copy of suggested conditions it might impose.

The Tribunal's Determination on Sanction

30. In relation to Ms Gilsenan's submissions as to the absence of evidence provided by Dr Manieson, the Tribunal's position remains as it set out at paragraphs 22 to 29 in its impairment determination.

31. The decision as to the appropriate sanction to impose, if any, in this case is a matter for this Tribunal exercising its own judgement. In reaching its decision, the Tribunal has taken account of the SG in full. It has borne in mind that the purpose of any sanction is not to be punitive, but to protect patients and the wider public interest, although a sanction may have a punitive effect.

32. Throughout its deliberations, the Tribunal applied the principle of proportionality, balancing Dr Manieson's interests with the wider public interest. The public interest includes, amongst other things, the protection of patients, the maintenance of public confidence in the medical profession, and the promotion and maintenance of proper professional standards and conduct.

33. The Tribunal has already given a detailed determination on impairment and it has taken its findings into account during its deliberations on sanction.

Aggravating and Mitigating Factors

34. The Tribunal found the following to be aggravating factors:

- Dr Manieson's course of misconduct continued for at least six months
- The stage of Dr Manieson's career in the UK; a doctor with his level experience should have known better
- Dr Manieson's delayed full acceptance of his misconduct

35. The Tribunal found the following to be mitigating factors:

- Dr Manieson's full admissions at the outset of the hearing

- Dr Manieson's previous good character and his exemplary career in A&E to date
- Dr Manieson's motives were altruistic, albeit misguided
- The passage of time since the misconduct occurred with no recurrence
- Evidence of well-developed insight, as demonstrated when he gave evidence
- Evidence of apology and remorse
- Evidence of remediation, now adheres to GMC guidance and no longer prescribes for overseas patients, or patients who are not his own
- Dr Manieson's current work with his Trust in relation to prescriptions
- Positive testimonials

No Action

36. In coming to its decision as to the appropriate sanction, if any, to impose in Dr Manieson's case, the Tribunal first considered whether to conclude the case by taking no action.

37. The Tribunal considered that there were no exceptional circumstances in Dr Manieson's case which would justify it taking no action. The Tribunal noted that Dr Manieson did not seek to advance any exceptional circumstances. The Tribunal determined that in view of the serious nature of Dr Manieson's misconduct and its findings on impairment, it would be neither sufficient, proportionate nor in the public interest, to conclude this case by taking no action.

Conditions

38. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Manieson's registration. It has borne in mind that any conditions imposed would need to be appropriate, proportionate, workable and measurable.

39. The Tribunal took account of paragraphs 81, 82 and 84 of the SG in relation to conditions, as follows:

> *'81. Conditions might be most appropriate in cases:*
>
> *a …*
> *b involving issues around the doctor's performance*
> *c where there is evidence of shortcomings in a specific area or areas of the doctor's practice*
> *d ….*
>
> *82. Conditions are likely to be workable where:*
>
> *a. the doctor has insight*

b. a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings

c. the tribunal is satisfied the doctor will comply with them

d. the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised.

84. Depending on the type of case (eg health, language, performance or misconduct), some or all of the following factors being present (this list is not exhaustive) would indicate that conditions may be appropriate:

a. no evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage

b. identifiable areas of their practice are in need of assessment or retraining

c. willing to respond positively to retraining, with evidence that they are committed to keeping their knowledge and skills up to date throughout their working life, improving the quality of their work and promoting patient safety (Good medical practice, paragraphs 7–13 on knowledge, skills and performance and paragraphs …'

40. The Tribunal found Dr Manieson to be credible, sincere and passionate about his work. Dr Manieson was profusely apologetic and contrite. The Tribunal had no difficulty reaffirming its earlier determination that Dr Manieson is not liable to repeat his misconduct.

41. The Tribunal looked again at Dr G's November 2018 report set out in its impairment determination at paragraph 57. The Tribunal noted that this was the first formal remediation Dr Manieson had undertaken and that it appeared to be a turning point for his insight.

42. The Tribunal noted that Dr Manieson has taken up a proactive position in his department in relation to prescribing and is now a member of the Department's Prescribing Board and catalogues prescription mistakes for the A&E department. The Tribunal noted that Dr Manieson will be leading an audit on new style prescriptions at the Trust and it is proposed that he will present the audit findings at the next Prescribing Board meeting.

43. The Tribunal noted Dr Manieson's account of instances where clinical colleagues have asked him to prescribe antibiotics on an ad hoc basis which he now refuses as he is fully aware of the guidance on prescribing.

44. The Tribunal noted that Dr Manieson has no intention to prescribe for overseas patients again and that the overseas patients and colleagues he had spoken to understood and were sympathetic to his position.

45. The Tribunal also noted that Dr Manieson is now fully aware of the guidance relating to prescribing. The Tribunal noted that these matters were addressed at his appraisal in November 2018 and no concerns have been raised about his prescribing since the index complaints in 2017.

46. The Tribunal was satisfied that Dr Manieson has remedied his misconduct in relation to his prescribing practice and that Dr Manieson would not prescribe for overseas patients in the future. The Tribunal considered Dr Manieson had achieved a satisfactory level of insight.

47. The Tribunal remained satisfied that Dr Manieson is not liable to repeat his misconduct and therefore limb (a) of the statutory overarching objective is met.

48. The Tribunal has borne in mind the wider public interest in this case and that the public rightly expects doctors to follow the guidance issued by their regulator. The Tribunal is satisfied that Dr Manieson has insight into and has remedied his misconduct. However, the Tribunal is of the opinion that, given Dr Manieson's insight and remediation, a period of conditional registration would not be workable or appropriate. Furthermore, the Tribunal determined a period of conditional registration would not protect the wider public interest in that it would not be sufficient to promote and maintain public confidence in the medical profession or promote and maintain proper professional standards and conduct for members of the medical profession.

Suspension

49. The Tribunal then went on to consider whether suspending Dr Manieson's registration would be appropriate and proportionate. The SG states:

> *'91. Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*
>
> *92. Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and*

> *maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with*
> *continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).*
>
> *93. Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions (see paragraphs 24–49).*
>
> *97. Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> > *a. A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.*
> >
> > *…*
> >
> > *e. No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.*
> >
> > *f. No evidence of repetition of similar behaviour since incident.*
> >
> > *g. The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'*

50. The Tribunal found Dr Manieson's misconduct to be serious. It found that Dr Manieson had breached the principles set out in Good Medical Practice and failed to follow the guidance on prescribing. Dr Manieson fully admitted his misconduct and has shown both insight and remediation. He is not liable to repeat his misconduct. The Tribunal is of the opinion that Dr Manieson's misconduct is not fundamentally incompatible with his continued registration and that his complete removal from the medical register would not be in the public interest. However, the Tribunal determined that a suspension would be proportionate and sufficient to promote and maintain public confidence in the medical profession and promote and maintain proper professional standards and conduct for members of the medical profession.

51. In considering the length of suspension the Tribunal has borne in mind paragraphs 99 and 100 of the SG, as follows:

> *99. The length of the suspension may be up to 12 months and is a matter for the tribunal's discretion, depending on the seriousness of the particular case.*
>
> *100. The following factors will be relevant when determining the length of suspension:*
>
> *a …*
>
> *b. the seriousness of the findings and any mitigating or aggravating factors (as set out in paragraphs 24–60)*
>
> *c …'*

52. Given the particular circumstances of this case, as set out above, and balancing the mitigating and aggravating factors, the Tribunal is of the opinion that a period of one month's suspension is sufficient to address the wider public interest in this case.

53. The Tribunal is satisfied that Dr Manieson has good insight into and has remedied his misconduct. No further concerns have been raised since July 2017. The Tribunal considered the public interest would be served by facilitating Dr Manieson's early return to clinical practice whilst sending a signal to the doctor, the profession and the public about what is regarded as conduct unbefitting a registered doctor.

54. In relation to a review the Tribunal took account of paragraph 164 in the SG, which states:

> *'164. In some misconduct cases it may be self-evident that, following a short suspension, there will be no value in a review hearing. However, in most cases where a period of suspension is imposed, and in all cases where conditions have been imposed, the tribunal will need to be reassured that the doctor is fit to resume practice – either unrestricted or with conditions or further conditions. A review hearing is therefore likely to be necessary, so that the tribunal can consider whether the doctor has shown all of the following (by producing objective evidence):*
>
> *a. they fully appreciate the gravity of the offence*
>
> *b. they have not reoffended*

c. they have maintained their skills and knowledge

d. patients will not be placed at risk by resumption of practice or by the imposition of conditional registration.'

55. The Tribunal considered that it is not necessary to direct a review. It is satisfied that after his period of suspension Dr Manieson will be able to return to safe practice. He has been in practice since the Allegation arose and has demonstrated a good level of insight and remediation.

Erasure

56. The Tribunal considered that erasure would not be appropriate in this case.

Determination on Immediate Order - 20/12/2018

1. Having determined that Dr Manieson's registration be subject to suspension, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

2. On behalf of the GMC, Ms Gilsenan informed the Tribunal that the GMC makes no application for an immediate order and she confirmed that there is no interim order on Dr Manieson's registration.

3. On behalf of Dr Manieson, Ms Mitchell-Dunn made no submissions in relation to an immediate order.

The Tribunal's Determination

4. The Tribunal has determined that, given that there are no patient safety concerns and that there are no issues regarding Dr Manieson's clinical practice, it is not necessary to make an order suspending his registration immediately.

5. This means that Dr Manieson's registration will be suspended from the Medical Register 28 days from today, unless he lodges an appeal. If Dr Manieson does lodge an appeal he will remain free to practise unrestricted until the outcome of any appeal is known.

6. That concludes this case.

Confirmed
Date 20 December 2018 Mr Richard Tutt, Chair

Schedule 1

	Name on prescription	Date of birth	Address used on prescription	Date of prescription
1.	XXX	XXX	XXX	12 January 2017
2.	XXX	XXX	XXX	12 January 2017
3.	XXX	XXX	XXX	28 January 2017
4.	XXX	XXX	XXX	28 March 2017
5.	XXX	XXX	XXX	28 January 2017
6.	XXX	XXX	XXX	28 March 2017
7.	XXX	XXX	XXX	3 July 2017
8.	XXX	XXX	XXX	28 January 2017
9.	XXX	XXX	XXX	28 March 2017
10	XXX	XXX	XXX	12 February 2017
11	XXX	XXX	XXX	12 February 2017
12	XXX	XXX	XXX	2 May 2017
13	XXX	XXX	XXX	12 February 2017
14	XXX	XXX	XXX	12 February 2017
15	XXX	XXX	XXX	3 July 2017
16	XXX	XXX	XXX	8 March 2017
17	XXX	XXX	XXX	5 June 2017
18	XXX	XXX	XXX	8 April 2017
19	XXX	XXX	XXX	14 April 2017
20	XXX	XXX	XXX	5 June 2017
21	XXX	XXX	XXX	2 May 2017

2	XXX	XXX	XXX	5 June 2017
2	XXX	XXX	XXX	3 July 2017
2	XXX	XXX	XXX	2 May 2017
2	XXX	XXX	XXX	20 May 2017
2	XXX	XXX	XXX	2 May 2017
2	XXX	XXX	XXX	20 May 2017
2	XXX	XXX	XXX	20 May 2017
2	XXX	XXX	XXX	3 July 2017
3	XXX	XXX	XXX	3 July 2017
3	XXX	XXX	XXX	3 July 2017

Schedule 2

XXX

Schedule 3

XXX