Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 25/02/2019 - 15/03/2019
28/10/2019 - 29/10/2019

Medical Practitioner’s name: Dr David DIGHTON

GMC reference number: 0206150

Primary medical qualification: MB BS 1966 University of London

Type of case
New - Misconduct

Outcome on impairment
Impaired

Summary of outcome
Suspension, 12 months.
Review hearing directed
Immediate order imposed

Tribunal:

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<tr>
<th>Legally Qualified Chair</th>
<th>Miss Gillian Temple-Bone</th>
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<td>Lay Tribunal Member:</td>
<td>Dr Nigel Westwood</td>
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<td>Medical Tribunal Member:</td>
<td>Dr Nitesh Raithatha</td>
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<tr>
<th>Tribunal Clerk:</th>
<th>Miss Emma Saunders</th>
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<td>(25/02/2019 - 15/03/2019)</td>
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<td>Ms Jacqueline Kramer</td>
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<td>(28/10/2019 - 29/10/2019)</td>
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Attendance and Representation:

| Medical Practitioner: | Present and represented (25/02/2019, 26/02/2019 AM, 14/03/2019 - 15/03/2019, 28/10/2019) |
|                       | Not present and represented (26/02/2019 PM, 27/02/2019 - 01/03/2019, 04/03/2019 - 11/03/2019, 29/10/2019) |
| Medical Practitioner’s Representative: | Mr Stephen Brassington, Counsel, instructed by RadcliffesLeBrasseur |
| GMC Representative:   | Ms Elizabeth Dudley-Jones, Counsel |
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Attendance of Press / Public
In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public. In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

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 - 11/03/2019

Background

1. Dr Dighton qualified in 1966. The Tribunal has not had sight of Dr Dighton’s Curriculum Vitae. The expert in these proceedings, in her report, sets out “Dr Dighton is an independent doctor working from The Loughton Clinic in Essex (XXX) where he describes himself as practising Cardiology and General Medicine as a consulting physician. He describes his practice as including general medical outpatients (diagnostic and management), some general practice (minor complaints), non-invasive cardiology (ECG, exercise testing and echocardiography) and laboratory testing (via Doctor’s Lab, London)”. It appears that this information has come from the website pertaining to Dr Dighton’s place of work. The date of accessing the website is unknown.

2. The allegation that has led to Dr Dighton’s hearing relates to his treatment and management of Patient A between 2011 and 2017. Patient A attended a consultation with Dr Dighton on 1 November 2011. Patient A was not referred to Dr Dighton and he would have had no knowledge of her medical history, other than that which she told him. Over the subsequent years to 2017 Patient A sought and obtained multiple prescriptions from Dr Dighton for the drugs zolpidem also known as stilnoct (sleeping tablet), co-proxamol (strong painkiller), dihydrocodeine (strong painkiller), mirtazapine (antidepressant), and diazepam (a tranquiliser). Over the same period of time, Patient A obtained multiple prescriptions from her General Practitioner (GP) for drugs, including antidepressants, diazepam, zolpidem and dihydrocodeine.

3. On 12 July 2011 Patient A is described in the medical records suffering from mixed anxiety and depression; poor sleep; some intermittent suicidal ideation but no plans to act on these thoughts; she is finding it very difficult to get out of the house and spends a lot of time in bed (assessment by Dr B, Associate Specialist in Psychiatry). Later, on 23 June 2017, a Consultant Psychiatrist diagnosed Patient A as having...
developed a depressive disorder, in the context of post-traumatic stress disorder (PTSD), shoulder pain and prescription drug dependency.

4. It is alleged that Dr Dighton excessively prescribed a number of different medications to Patient A; failed to adequately assess or appropriately refer her to mental health services; kept inadequate records and, save for April 2012, did not inform her GP. Throughout Dr Dighton lacked the adequate expertise to treat Patient A.

5. By a letter dated 11 July 2012, Dr Dighton confirmed a conversation about Patient A with the local pharmacist. He stated that he was aware from the start that Patient A was a potential problem and that she demonstrated the behaviour of an addict.

6. Dr Dighton was referred to the General Medical Council (GMC) by NHS England (NHSE). This followed an investigation by NHSE in 2017 into Dr Dighton’s prescribing of controlled drugs to Patient A, which had been flagged locally as a cause for concern.

The Outcome of Applications Made during the Facts Stage

7. The Tribunal granted the GMC’s application, made pursuant to Rule 17(6) of the GMC (Fitness to Practise) Rules 2004, as amended ('the Rules'), for the amendment of paragraph 6(b)(i), Schedule 2 and paragraph 6(e)(ii) of the Allegation. The Tribunal refused the GMC’s application in relation to adding paragraph 8 and Schedule 6 to the Allegation. The Tribunal’s full decision is included at Annex A.

8. The Tribunal refused the GMC’s application, made pursuant to Rule 34(1) of the Rules, for the admission of evidence relating to a GMC warning issued to Dr Dighton in July 2016. The Tribunal granted the GMC’s application for the admission of a document dated 28 July 2016 (Exhibit C2), albeit with reference to the warning removed. The Tribunal’s full decision is included at Annex B.

9. The Tribunal refused Dr Dighton’s application that the Tribunal should recuse itself. The Tribunal’s full decision on the application is included at Annex C.

10. The Tribunal granted the GMC’s application, made pursuant to Rule 17(6) of the Rules, for a further amendment to the Allegation. The amendment to paragraph 6 of the Allegation was not opposed and the Tribunal concluded that the amendment could be made without injustice. The agreed amendment was:

"6. Between 5 January 2017 and 10 October 2017:

   a. you issued the prescriptions for co-proxamol on the occasions set out in Schedule 2 to Patient A; and"
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b. when issuing the prescriptions referred to at paragraph 6(a) you failed to:

   i. adequately assess Patient A’s pain;

   ii. try alternative painkillers;

   iii. explain the risks of taking co-proxamol to Patient A;

   iv. explain that co-proxamol was unlicensed to Patient A;

   v. monitor the frequency of the prescriptions issued;”

[With the subsequent sub-paragraphs of paragraph 6 of the Allegation renumbered from b-e to c-f].

11. The Tribunal granted Dr Dighton’s application, made pursuant to Rule 17(2)(g) of the Rules, that there is no case to answer in relation to a number of sub-paragraphs of the Allegation. The Tribunal also determined to refuse Dr Dighton’s application in relation to a number of different sub-paragraphs of the Allegation. The Tribunal’s full decision on the application is included at Annex D.

12. The Tribunal granted Dr Dighton’s application, made pursuant to Rule 17(6) of the Rules, for the amendment of the Allegation for the deletion of paragraph 6(c)(ii) of the Allegation. The Tribunal’s full decision on the application is included at Annex E.

13. The Tribunal granted the GMC’s application, made pursuant to Rule 17(6) of the Rules, for a further amendment to the Allegation. The amendment to paragraph 4 of the Allegation was not opposed and the Tribunal concluded that the amendment was appropriate given its reasoning in Annex D that the date was incorrect. The Tribunal determined that the amendment was to correct an inaccuracy and could be made without injustice. The agreed amendment was:

   “4. On 13 October December 2016 you consulted with Patient A and you failed to:”

The Allegation and the Doctor’s Response

14. The Allegation made against Dr Dighton is as follows:

   That being registered under the Medical Act 1983 (as amended):

   1. On 1 November 2011 you consulted with Patient A and you:
a. failed to obtain an adequate medical history in that you did not ask Patient A about their:

i. past medical history, including whether Patient A had any previous serious illnesses or operations;  
   Deleted after a successful Rule 17(2)(g) application

ii. current medication;  
   Deleted after a successful Rule 17(2)(g) application

b. prescribed lorazepam to Patient A when it is not clinically indicated for the treatment of vertigo;  
   To be determined

c. failed to inform Patient A’s GP that you had issued Patient A with a prescription for:

i. Stemetil;  
   To be determined

ii. lorazepam.  
   To be determined

2. On one or more occasion between 1 November 2011 and 10 October 2016 you:

a. prescribed the following medications to Patient A:

i. zolpidem;  
   Admitted and found proved

ii. diazepam;  
   Admitted and found proved

iii. dihydrocodeine;  
   Admitted and found proved

iv. mirtazapine;  
   Admitted and found proved

v. co-proxamol;  
   Admitted and found proved

b. failed to inform Patient A’s GP that you had prescribed the medications set out at paragraphs 2(a)(i) to (v) to Patient A.
To be determined

3. On 10 October 2016 you consulted with Patient A and you failed to:

   a. obtain an adequate medical history in that you did not ask Patient A about:

      i. their mood;
      Deleted after a successful Rule 17(2)(g) application

      ii. their anxiety levels;
      Deleted after a successful Rule 17(2)(g) application

      iii. their sleep;
      Deleted after a successful Rule 17(2)(g) application

      iv. their eating;
      Deleted after a successful Rule 17(2)(g) application

      v. their concentration;
      Deleted after a successful Rule 17(2)(g) application

      vi. any evidence of features of hallucinations or delusions;
      Deleted after a successful Rule 17(2)(g) application

   b. adequately assess and examine Patient A in that you did not:

      i. ask Patient A regarding pain control;
      Deleted after a successful Rule 17(2)(g) application

      ii. assess Patient A’s:

         aa. mood;
         Deleted after a successful Rule 17(2)(g) application

         ab. speech;
         Deleted after a successful Rule 17(2)(g) application

         ac. anxiety levels;
         Deleted after a successful Rule 17(2)(g) application

         ad. communication;
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Deleted after a successful Rule 17(2)(g) application

ae. suicidal ideation;
Deleted after a successful Rule 17(2)(g) application

e. implement an adequate and appropriate treatment plan in that you did not adequately assess and examine Patient A as set out at paragraphs 3(b)(i) to (ii) above before deciding not to change their medication or refer them to a psychiatrist;
Deleted after a successful Rule 17(2)(g) application

d. keep an adequate record in that you did not record your assessment and examination of Patient A as set out at paragraphs 3(b)(i) to (ii);
Admitted and found proved

e. inform Patient A’s GP of the medications that you were prescribing to her every two weeks.
To be determined

4. On 13 October December 2016 you consulted with Patient A and you failed to:

a. obtain an adequate medical history in that you did not ask Patient A about any other symptoms, including:

i. stomach upset;
Deleted after a successful Rule 17(2)(g) application

ii. vomiting;
Deleted after a successful Rule 17(2)(g) application

iii. abdominal pain;
Deleted after a successful Rule 17(2)(g) application

iv. bowel disturbance;
Deleted after a successful Rule 17(2)(g) application

v. bladder symptoms;
Deleted after a successful Rule 17(2)(g) application

vi. weight loss;
Deleted after a successful Rule 17(2)(g) application
b. inform Patient A’s GP about:
   i. Patient A’s illness;  
      **To be determined**
   ii. the investigations you were performing.  
      **To be determined**

5. Between 24 July 2017 and 10 October 2017:
   a. you issued the prescriptions for mirtazapine on the occasions set out in Schedule 1 to Patient A;  
      **Admitted and found proved**
   b. the prescriptions as referred to at paragraph 5(a) above were excessive in that:
      i. they were issued at intervals of between seven to 15 days;  
      **Admitted and found proved**
      ii. Patient A could have exceeded the maximum daily dose of 45mg.  
      **Admitted and found proved**

6. Between 5 January 2017 and 10 October 2017:
   a. you issued the prescriptions for co-proxamol on the occasions set out in Schedule 2 to Patient A; and  
      **Admitted and found proved**
   b. when issuing the prescriptions referred to at paragraph 6(a) you failed to:
      i. adequately assess Patient A’s pain;  
      **Deleted after a successful Rule 17(2)(g) application**
      ii. try alternative painkillers;  
      **Deleted after a successful Rule 17(2)(g) application**
      iii. explain the risks of taking co-proxamol to Patient A;  
      **Deleted after a successful Rule 17(2)(g) application**
      iv. explain that co-proxamol was unlicensed to Patient A;
Deleted after a successful Rule 17(2)(g) application

v. monitor the frequency of the prescriptions issued;

Admitted and found proved

b. c. the prescriptions as referred to at paragraph 6(a) above were excessive in that:

i. the interval between one or more of those prescriptions was too short in order for Patient A to be taking co-proxamol according to the prescribed dose of one tablet four times daily and/or one tablet three times daily;

Admitted and found proved

ii. you failed to restrict the number of tablets provided to Patient A to the dose you had prescribed;

Amended under Rule 17(6)

e. d. you issued the prescriptions for zolpidem on the occasions set out in Schedule 3 to Patient A, which was excessive in that the intervals between those prescriptions suggested that Patient A was exceeding the recommended dose of 10mg daily;

Admitted and found proved

d. e. you issued the prescriptions for dihydrocodeine on the occasions set out in Schedule 4, which were excessive in that the intervals between those prescriptions suggested that Patient A was exceeding the prescribed dose of one tablet three times daily;

Admitted and found proved

e. f. you issued the prescriptions set out in Schedules 1 to 5 without:

i. regularly assessing Patient A’s mental state and suicide risk;

To be determined

ii. appropriately referring Patient A to mental health services;

To be determined

iii. informing Patient A’s GP;

To be determined

iv. adequate expertise to do so.

Admitted and found proved
7. You failed to keep an adequate record in that you did not record:

   a. between 1 November 2011 and 5 January 2017 any:
      
      i. mental health issues;  
         **Admitted and found proved**
      
      ii. assessment of Patient A’s mental health;  
         **Admitted and found proved**

   b. why the following medications were prescribed to Patient A:
      
      i. co-proxamol;  
         **Admitted and found proved**
      
      ii. dihydrocodeine;  
         **Admitted and found proved**
      
      iii. mirtazapine;  
         **Admitted and found proved**
      
      iv. diazepam;  
         **Admitted and found proved**
      
      v. zolpidem;  
         **Admitted and found proved**

   c. all of your interactions with Patient A between 1 November 2011 and 10 October 2017 during which you:
      
      i. discussed or monitored Patient A’s clinical care;  
         **Admitted and found proved**
      
      ii. issued a prescription for the medications set out at paragraphs 7(b)(i) to (v).  
         **Admitted and found proved**

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct.

**To be determined**

**The Admitted Facts**
15. At the outset of these proceedings, through his counsel, Mr Brassington, Dr Dighton made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these as admitted and found proved.

The Facts to be Determined

16. In light of Dr Dighton’s response to the Allegation made against him, the Tribunal was required to determine whether Dr Dighton prescribed lorazepam to Patient A on 1 November 2011 when it was not clinically indicated for the treatment of vertigo; whether he failed to inform Patient A’s GP that he had issued a prescription for stemetil and lorazepam on 1 November 2011; whether on one or more occasions, between 1 November 2011 and 10 October 2016, Dr Dighton failed to inform Patient A’s GP that he had prescribed zolpidem, diazepam, dihydrocodeine, mirtazapine, co-proxamol; whether, on 10 October 2016, he had failed to inform Patient A’s GP of the medications that he was prescribing to her every two weeks; whether Dr Dighton consulted with Patient A on 13 December 2016 and failed to inform Patient A’s GP about her illness and the investigations he was performing; and whether, between 5 January 2017 and 10 October 2017, Dr Dighton issued the prescriptions set out in Schedules 1 to 5 without regularly assessing Patient A’s mental state and suicide risk, appropriately referring Patient A to mental health service and informing Patient A’s GP.

Factual Witness Evidence

17. The Tribunal received evidence on behalf of the GMC from the following witness who was not called to give oral evidence:

- Dr C, Assistant Medical Director for NHSE Midlands and East and Controlled Drugs Accountable Officer (CDAO) for that Area Team. Her statements were dated 8 September 2018 and 27 September 2018 and included a number of accompanying exhibits.

Expert Witness Evidence

18. The Tribunal received evidence from Dr D, GMC expert witness and GP Principal. She has worked as a GP Clinical Adviser to the Parliamentary and Health Service Ombudsman, a GP Trainer and GP Clinical Adviser Complaints for NHSE NWAT February 2017 to March 2018. She provided an expert report dated 28 September 2018 to assist the Tribunal in understanding the professional standards to be expected of a GP. An email of corrections dated 24 February 2019 from Dr D to the GMC was provided, as well as a supplementary expert report dated 1 March 2019. Dr D gave oral evidence to the Tribunal, in person.
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19. In relation to the medications listed in the Allegation, the Tribunal had regard to the definitions provided by Dr D in her expert report dated 28 September 2018, as follows:

- lorazepam: a benzodiazepine tranquilliser with addictive properties
- stemetil: a drug used for vertigo
- co-proxamol: a strong painkiller which was withdrawn from being licenced by the MHRA due to the risk of fatality in overdose
- dihydrocodeine: a strong painkiller related to morphine with addictive properties
- mirtazapine: an antidepressant
- diazepam: a benzodiazepine tranquilliser with addictive properties
- zolpidem: a sleeping tablet with addictive properties

**Documentary Evidence**

20. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included, but was not limited to: Patient A’s GP records provided by The Loughton Surgery (Patient A’s GP Surgery) dated May 2011 to June 2018; Dr Dighton’s medical records for Patient A dated November 2011 to January 2018; and the private prescriptions issued by Dr Dighton to Patient A from 5 January 2017 to 10 October 2017.

**The Tribunal’s Approach**

21. The Tribunal has now heard all the oral evidence which is to be presented, and has further written evidence within the bundle which is agreed, to take into consideration. It is upon this body of evidence that the Tribunal must make its findings. The Tribunal is entitled to draw inferences (that is to say to draw common sense conclusions based on the available evidence), but the Tribunal ought not to speculate as to whatever other evidence may have been available. Speculation is little more than guesswork.

22. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Dighton does not need to prove anything. Dr Dighton chose not to give evidence at this stage of the hearing and the Tribunal drew no adverse inference from this. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the matters alleged occurred.

23. The Tribunal must consider each allegation separately on its merits. It is possible (depending on the circumstances) that the Tribunal’s decision on one of the allegations might assist it in coming to a conclusion on another of the allegations. Nevertheless, the Tribunal should reach a separate, independent, decision on each of the allegations, having focused on each separately and having formed a separate decision about it.
24. Relevant case-law includes the words of Hoffman LJ in the case of *Re B* [2008] UKHL 35:

"If a legal rule requires a fact to be proved (a “fact in issue”), a judge or jury must decide whether or not it happened. There is no room for a finding that it might have happened. The law operates a binary system in which the only values are 0 and 1. The fact either happened or it did not. If the tribunal is left in doubt, the doubt is resolved by a rule that one party or the other carries the burden of proof. If the party who bears the burden of proof fails to discharge it, a value of 0 is returned and the fact is treated as not having happened. If he does discharge it, a value of 1 is returned and the fact is treated as having happened."

The Tribunal’s Analysis of the Evidence and its Findings

25. The Tribunal has considered each outstanding paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts.

Consent

26. The criticism of Dr Dighton contained within paragraphs 1(c)(i) and (ii), 2(b), 3(e), 4(b), 6(f)(iii) of the Allegation is that he did not inform Patient A’s GP of his management of Patient A. The Tribunal therefore had to determine whether, between 1 November 2011 and 10 October 2017, Dr Dighton had Patient A’s consent to communicate with her GP.

27. The Tribunal had regard to the principles of consent, confidentiality and a duty to act in Patient A’s best interests, assisted by the guidance in paragraph 44(a) of GMP, paragraphs 8 to 10 and 24 to 35 of the GMC’s Confidentiality Guidance (2009), and of paragraphs 9 to 15 of the GMC’s Confidentiality Guidance (2017). The Tribunal concluded from its review of these documents that, in routine practice, there is a positive onus on every doctor to communicate with other health professionals where it is in the patient’s best interests to do so. Implied consent is sufficient for these purposes.

28. The Tribunal noted that, in the controlled drug patient management report dated 10 August 2017, Dr Dighton records, in the entry ‘Patient History’, “concern about overuse of benzodiazepine and analgesics raised with GP (see letter to GP 12 April 2012) and with a pharmacist (11.07.12)... I was concerned that they might be getting prescriptions from multiple sources”. The Tribunal took account of the communications that took place between Dr Dighton and Patient A’s GP:

- Telephone conversation with Patient A’s GP on 12 April 2012;
- Letter from Dr Dighton to Patient A’s GP also 12 April 2012;
- Letter to Patient A dated 10 April 2012;
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- Handwritten records by Dr Dighton of his intention to contact the GP on 12 April 2012;
- Notice to all patients taking sleeping tablets dated 28 July 2016, which included Patient A, and in which Dr Dighton sets out his obligations that "Good Practice necessitates doctors communicating with one another";
- Email from Dr Dighton to NHS England on 31 August 2017, in which he stated that there had been no clinical need for him to contact Patient A’s GP further: "I can confirm that Patient A’s GP is aware of my co-proxamol prescribing. I had a full discussion with the GP on 12 April 2012. It was then agreed that I continue to prescribe co-proxamol for Patient A I have not had any concerns about para-suicide, or overdosing, during the time I have overseen her care; and because her renal function has remained normal, and he would not himself be prescribing them, there has been no clinical need to contact him further."

29. The Tribunal took account of the matters Mr Brassington raised:

- Patient A’s response to questions asked by the Controlled Drugs Agency, complaining about their intervention. It is dated 19 January 2018. Patient A records her choice to be cared for by Dr Dighton and her objection to being treated by an NHS GP.

- Patient A’s objection in the same document to the Controlled Drugs Agency copying the private prescriptions issued by Dr Dighton to Patient A with her personal details on, without her knowledge. She states that this is a breach of doctor/patient confidentiality and not in her best interests.

- A letter from Dr Dighton to Patient A on 4 December 2017 explaining he needs to refer her to be managed by her GP and asks "please let me know who that now is”.

30. The Tribunal noted that despite Patient A’s responses recorded on 19 January 2018 to the Controlled Drugs Agency, that she chose to be cared for by Dr Dighton, she had: on 28 November 2017 attended her GP about a lump on her neck; attended her GP on 29 November 2017 and obtained 30mg x 196 tablets of dihydrocodeine, 15mg x 49 mirtazapine tablets, 10mg x 56 zolpidem tablets from her GP and further prescriptions on 19 December 2017, 10 January 2018 and 29 January 2018. Clearly Patient A was content to be a patient at her GP Surgery as well as consulting Dr Dighton.

31. The Tribunal do not accept Mr Brassington’s submissions that the evidence indicates that Patient A refused consent for Dr Dighton to communicate with her GP. The Tribunal noted Dr Dighton’s awareness of prescription issues from the outset of his consultations with Patient A.
32. Dr Dighton stated in a referral letter to a psychiatrist, Dr M, dated 16 August 2012 that Patient A overused sleeping drugs "zolpidem and diazepam" and that "she and her husband used each other's tablets, making regulating drug taking somewhat difficult".

33. Dr Dighton wrote to the pharmacist on 11 July 2012 that he "was aware right from the start that they [Patient A and husband] were a potential problem, claiming that they had lost tablets, that they had left them in Spain... this is clearly the behaviour of addicts".

34. The Tribunal determined that the totality of evidence before it demonstrated that Dr Dighton was communicating medical information about Patient A to other practitioners on the basis of Patient A's implied consent and that Patient A had not explicitly refused consent for data sharing at any juncture.

35. Communications between Dr Dighton and the GP took place in 2012 and not thereafter because Dr Dighton admits, in his view, "there was no clinical need" (Dr Dighton's email 31 August 2017).

Paragraph 1

36. Dr Dighton made an admission in relation to the stem of paragraph 1 of the Allegation, in that he consulted with Patient A on 1 November 2011.

Paragraph 1(b)

37. The Tribunal considered whether Dr Dighton prescribed lorazepam to Patient A when it was not clinically indicated for the treatment of vertigo. It had regard to Dr Dighton's handwritten record of his consultation with Patient A on 1 November 2011 in which he recorded "Rx... lorazepam". The Tribunal noted that Patient A had also been prescribed lorazepam in the same period time by her NHS GP for anxiety.

38. The Tribunal took account of Dr D's opinion that lorazepam is not clinically indicated for the treatment of vertigo, a matter that was accepted by both parties.

39. The Tribunal determined that, factually, and based on Dr D's evidence, Dr Dighton did prescribe lorazepam to Patient A when it was not clinically indicated for the treatment of vertigo. The Tribunal has yet to determine the reason why Dr Dighton prescribed lorazepam, a matter which it will consider when judging whether his actions amounted to misconduct. The Tribunal found this sub-paragraph of the Allegation proved.

Paragraphs 1(c)(i) and (ii)
40. The Tribunal considered whether Dr Dighton consulted with Patient A on 1 November 2011 and failed to inform her GP that he had issued a prescription for stemetil and lorazepam. The Tribunal had regard to Dr Dighton’s handwritten record of his consultation with Patient A on 1 November 2011 of the prescribing of stemetil and lorazepam. It noted that there was nothing in that record to say that he had spoken or was going to write to Patient A’s GP.

41. The Tribunal took account of Patient A’s GP records, in which there was also a consultation recorded on 1 November 2011 but nothing in that correspondence record to show that that Dr Dighton had corresponded with or contacted the GP.

42. The Tribunal noted that Patient A’s GP records include correspondence in 2011, including letters from Sainsbury’s dated 2 September 2011 about Patient A, and from other healthcare professionals.

43. At the time, Patient A had been referred to Mr E, Consultant ENT/Head and Neck Surgeon, and had consultations with him on 28 October 2011 and 4 November 2011. His letters to the GP are included in Patient A’s GP records, received by them on 10 November 2011 and 14 November 2011. Mr E referred Patient A to a Mr F.

44. The next correspondence in the GP records is from the Accident and Emergency department at Whipps Cross University Hospital NHS Trust as received on 16 November 2011; and a letter from Dr B, Associate Specialist in Psychiatry, received on 22 December 2011. That letter dated 14 December 2011 informed the GP that Patient A had failed to attend her last two outpatient appointments and he was therefore discharging her back to GP care.

45. On 24 October 2011 Patient A was prescribed 28 tablets of zolpidem by her GP to help her sleep. On 1 November 2011 Patient A attended the GP surgery at 15:08 requesting more sleeping tablets. Her request was denied.

46. The Tribunal considered that this was the background to Patient A’s attendance with Dr Dighton on 1 November 2011. The Tribunal was mindful that there was no reference in the GP records to Dr Dighton having informed them of his consultation with Patient A.

47. The Tribunal also looked ahead in time in Patient A’s GP records. It took account of the entry on 12 April 2012 at 12:08:

"Asked to contact Dr Dighton, Cardiologist... who wanted to speak re: Patient A... He is concerned that patient has been seeing them for diazepam prescriptions saying has no NHS GP, he has written a letter to the surgery, on its way.

Diagnosis: Telephone encounter
Plan: Thanked him for bringing this to our notice."
The Tribunal was of the view that this suggested that this was Dr Dighton’s first contact with Patient A’s GP, especially as he makes reference to having been told that Patient A did not have an NHS GP.

48. The Tribunal had regard to the possibilities of what took place:

1. Dr Dighton did not inform Patient A’s GP on 1 November 2011;
2. Dr Dighton informed Patient A’s GP verbally, by calling or speaking to them face to face - but this was not noted in Patient A’s medical records by either the GP or Dr Dighton;
3. Dr Dighton informed Patient A’s GP in writing, by letter, email or other form of written communication - but this was not noted in Patient A’s medical records by either the GP or Dr Dighton;
4. Dr Dighton sent copies of the prescriptions to Patient A’s GP - but they were either not received by the GP or not recorded in Patient A’s medical records by the GP.

49. Mr Brassington urged the Tribunal to accept that an absence of evidence was not evidence. The Tribunal, whilst recognising the absence of evidence that Dr Dighton informed Patient A’s GP of his prescribing lorazepam and Stemetil on 1 November 2011, took into consideration the background of Patient A’s medical history with the GP during October and November 2011 and the action and recordings of communication between Dr Dighton and the GP in April 2012, some five months later. The Tribunal was mindful that Dr Dighton was clearly under the misapprehension that Patient A did not have a GP in April 2012 and so it can be inferred that he did not know that there was a GP some five months earlier. It is therefore more likely than not that Dr Dighton did not know of Patient A’s GP on 1 November 2011 and had taken no steps to identify whether she had a GP at that time.

50. The evidence before the Tribunal demonstrated that Patient A’s GP Practice had an effective system for logging incoming communications. The lack of any reference to communications from Dr Dighton in the GP record, together with Dr Dighton’s interaction with Patient A’s GP in 2012, led the Tribunal to determine that it was more likely than not that Dr Dighton had not communicated with Patient A’s GP in relation to his prescribing on 1 November 2011.

51. The Tribunal accepted the evidence of Dr D that Dr Dighton had a duty to inform Patient A’s GP of the drugs he was prescribing. The Tribunal found that he failed to do so.

52. The Tribunal found both parts of this sub-paragraph of the Allegation proved.

Paragraph 2
53. Dr Dighton made an admission in relation to the stem of paragraph 2 of the Allegation, as to the timings being between 1 November 2011 and 10 October 2016.

Paragraph 2(b) in relation to 2(a)(i): zolpidem and 2(a)(ii): diazepam

54. The Tribunal had regard to a letter from Dr Dighton to Patient A’s GP dated 12 April 2012, which was stamped as received in her GP records on 23 April 2012. In the letter, Dr Dighton stated:

"Thank you very much for speaking to me about this patient and her medication. Clearly, she XXX have been trying to get prescriptions from both of us.
At a meeting with them recently I made them choose who would give them further prescriptions for diazepam and stilnoct [zolpidem]. Since they wished to attend Loughton Clinic for this service perhaps we can agree that you give no further prescriptions for these items."

55. The Tribunal inferred from the letter that Dr Dighton had written to Patient A’s GP to say that he would be prescribing zolpidem and diazepam to her.

56. The Tribunal determined that it could make a reasonable and proper inference that Patient A’s GP would have read the letter to mean that Dr Dighton was going to prescribe these two medications on an ongoing basis as he asked the GP to give no further prescriptions for them.

57. The Tribunal found paragraph 2(b) of the Allegation not proved in relation to 2(a)(i) and (ii).

Paragraph 2(b) in relation to 2(a)(v): co-proxamol

58. The Tribunal has not seen any information in Patient A’s GP records that they were aware that Dr Dighton was prescribing dihydrocodeine, mirtazapine or co-proxamol to Patient A. It noted that Dr Dighton made an admission to the Allegation that he prescribed co-proxamol to Patient A, on one or more occasions between 1 November 2011 and 10 October 2016.

59. The Tribunal took account of an email from Dr Dighton to NHSE dated 31 August 2017, in which he stated:

"I can confirm that Patient A’s GP is aware of my Co-proxamol prescribing. I had a full discussion with the GP on 12 April 2012. It was then agreed that I continue to prescribe Co-proxamol for Patient A."

and that there had been "no clinical need to contact him further".
60. The Tribunal had regard to Dr Dighton’s handwritten record of his consultation with Patient A on 28 July 2016, in which he stated “Write to GP - address to be obtained by Patient”. There is no such letter in either Dr Dighton’s records or Patient A’s NHS GP records.

61. The Tribunal had regard to the possibilities of what took place:

1. Dr Dighton told Patient A’s GP verbally on 12 April 2012 - but this was not recorded in Patient A’s medical notes by the GP;
2. Dr Dighton was mistaken in his memory regarding his email to NHSE in August 2017.

62. The Tribunal noted the absence of a witness statement from Patient A’s GP and, in the circumstances, it determined that the evidence is contradictory. On the balance of probabilities, the Tribunal found paragraph 2(b) of the Allegation not proved in relation to 2(a)(v).

Paragraph 2(b) in relation to 2(a)(iii): dihydrocodeine

63. The Tribunal has no records of Dr Dighton’s prescriptions for Patient A between 1 November 2011 and 10 October 2016 but noted that he admits that he prescribed this drug on one or more occasions during that time period.

64. The Tribunal noted that Dr Dighton did not tell Patient A’s GP in April 2012 about him prescribing dihydrocodeine and so he failed to inform the GP then.

65. The Tribunal looked at Patient A’s GP records and noticed that, over the time period in question, the GP regularly prescribed large quantities of dihydrocodeine to Patient A. The Tribunal noted that there was no mention that the GP was aware of Dr Dighton prescribing dihydrocodeine to Patient A too, either in the records or in referrals to secondary health practitioners.

66. The Tribunal was mindful that the GP noted, on more than one occasion, concerns about Patient A and her use of dihydrocodeine. Entries on 24 September 2012, 23 October 2012 and 14 January 2014 recorded that they were trying to wean her off dihydrocodeine.

67. The Tribunal determined that it could draw a reasonable inference that, if the GP had known Dr Dighton was prescribing dihydrocodeine to her regularly, they would have referenced that in Patient A’s records in some way, i.e. reference to Patient A getting medication from other sources. There are no such records.

68. The Tribunal had regard to the record in Patient A’s GP notes of a questionnaire to the DVLA dated 4 November 2014 which confirmed to them that
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Patient A had a dependence on dihydrocodeine and her current prescriptions were: "dihydrocodeine - 30mg - 2 qds (2 x four times a day) and zolpidem 10mg”.

69. Further, on 12 March 2015, the GP notes record: "Plan: Write to DVLA - include that [Patient A] is no longer under psychiatrist and that she has reduced dose of dihydrocodeine to one tab bd". The Tribunal concluded that the GP communicated with DVLA on the basis of what they were prescribing, clearly not reflecting that she had another supply of the medication.

70. The Tribunal has found that Patient A’s GP was regularly prescribing dihydrocodeine to her during this period and it had been recorded that she might have been abusing the medication. There was no suggestion that she was obtaining the medication from another source, which would have been recorded in the GP notes. There is no note of any attempt by the GP to reach or explore the possibility of an agreement between practitioners as to who is to prescribe the medication. Further, Dr Dighton mentioned diazepam and zolpidem in his letter to the GP in April 2012 but he did not mention the dihydrocodeine. It also noted the correspondence with the DVLA where, when asked to give an account of Patient A’s medications, only the ones prescribed by the GP are recorded. The Tribunal concluded that, on the balance of probabilities, Dr Dighton failed to inform Patient A’s GP that he had prescribed dihydrocodeine. The Tribunal found paragraph 2(b) of the Allegation proved in relation to 2(a)(iii).

Paragraph 2(b) in relation to 2(a)(iv): mirtazapine

71. The Tribunal has no records of Dr Dighton’s prescriptions between 1 November 2011 and 10 October 2016 but noted that he admits that he prescribed this drug to Patient A on one or more occasions during that time period.

72. The Tribunal relies on this admission that Dr Dighton did prescribe mirtazapine but had regard to what evidence was before it to determine if he did or did not inform Patient A’s GP of the prescribing. The Tribunal does not know when within that five year period that Dr Dighton prescribed the mirtazapine. It had regard to Patient A’s GP records including psychiatrist letters to see if there is any reference to the prescription of mirtazapine within the relevant timeframe. The Tribunal noted that the psychiatric records are silent regarding this medication until 16 August 2017, when there is mention of "To start Mirtazapine 15 mg nocte". This suggests that the GP did not know about this medication being prescribed by Dr Dighton.

73. The Tribunal had regard to the possibilities of what took place:

1. Dr Dighton did not inform Patient A’s GP;
2. Dr Dighton informed Patient A’s GP verbally, by calling or speaking to them face to face - but this was not noted in Patient A’s medical records by either the GP or Dr Dighton;
3. Dr Dighton informed Patient A’s GP in writing, by letter, email or other form of written communication - but this was not noted in Patient A’s medical records by either the GP or Dr Dighton;

4. Dr Dighton sent copies of the prescriptions to Patient A’s GP - but they were either not received by the GP or not recorded in Patient A’s medical records by the GP.

74. The Tribunal took account of a letter from Dr Dighton to Patient A’s GP on 23 January 2018:

"I have kept to our earlier arrangement as the sole prescriber for this patient. Over the last 5 years there have been no significant clinical changes in her condition until recently, so I have not wished to write with information that in no way affects her management. This has now changed. She now takes mirtazapine 45 mgs daily, in addition to unchanged doses of diazepam 5mgs bd prn for anxiety and migraine prophylaxis, zolpidem 10mgs nocte, imigran nasal x 2/week, and co-proxamol (1-8 daily for pain)."

Therefore the Tribunal can conclude that Patient A took mirtazapine as at January 2018 but the use of the word "now" means that it cannot confirm if the same amount of this medication was prescribed by Dr Dighton to Patient A in the relevant timeframe.

75. The Tribunal had regard to the matrix of evidence before it. Although there were periods when Patient A was not seen by a psychiatrist via the GP, there is no mention that they were aware of Dr Dighton’s prescribing. Patient A was tried on a number of different anti-depressants by her GP, which probably would not have been prescribed if the GP had been informed by Dr Dighton of his prescribing. The Tribunal also referred to Dr Dighton’s comments in 2018 that he was acting as Patient A’s sole prescriber.

76. The Tribunal determined that there was a ‘failure’ on Dr Dighton’s behalf given the evidence of Dr D that it is important to keep a patient’s GP informed and that keeping them in the dark would not be in the patient’s best interests. The Tribunal found paragraph 2(b) of the Allegation proved in relation to 2(a)(iv).

Paragraph 3

Paragraph 3(e)

77. The Tribunal considered whether Dr Dighton consulted with Patient A on 10 October 2016 and failed to inform her GP of the medications he was prescribing to her every two weeks.
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78. The Tribunal had regard to Dr Dighton’s handwritten records of a consultation on 10 October 2016 that Patient A was "Stable on drug dose - regulated to every 2 weeks". It noted that there was no other reference in Dr Dighton’s records and no evidence in the GP records that the GP received any communication or copy prescriptions about the medications that Dr Dighton was prescribing.

79. The Tribunal took account of Dr D’s conclusions in her expert report dated 28 September 2018:

"10/10/2016: There is no mention of any prescriptions issued on this date but there is reference to prescriptions being issued every 2 weeks which were keeping Patient A stable. I do not have records of the prescriptions issued at this time to Patient A and therefore I am unable to comment on whether the prescriptions were appropriate.

... There is no record that Dr Dighton communicated with Patient A’s General Practitioner on 10/10/2016. The record notes that she is stable on her current medication provided every 2 weeks and that there was no need for a psychiatry referral. If Dr Dighton was prescribing a combination of zolpidem, diazepam, dihydrocodeine and co-proxamol for Patient A every 2 weeks and making decisions about her mental health between 2012 and 2016 then he should have communicated with Patient A’s General Practitioner...”

80. The Tribunal determined to accept Dr D’s interpretation that Dr Dighton was providing Patient A with two weeks’ worth of medications, did not inform the GP about it and that this was a failing on his part. The Tribunal found paragraph 3(e) of the Allegation proved.

Paragraph 4

Paragraph 4(b)(i) and (ii)

81. The Tribunal considered whether Dr Dighton consulted with Patient A on 13 December 2016 and failed to inform her GP about her illness and the investigations he was performing.

82. The Tribunal took account of Patient A’s GP record on 12 December 2016 at 15:13 that Patient A had attended but was anxious, tearful and reporting that she had lost 3 stone. The records listed Patient A’s family history of pancreatic cancer. The GP notes record "plan: in view of weight loss to have urgent bloods and USS" (referral for blood tests and an ultrasound). Her presentation that day was "very aggressive", including shouting in the waiting room and during the consultation. Further, it was recorded that she was assured that arrangements would be made for her symptoms to be investigated quickly. Patient A’s weight was recorded on that day as 10 stone 3 lbs.
83. In contrast, the Tribunal had regard to Dr Dighton’s handwritten record of a consultation on 13 December 2016 where he noted that Patient A was feeling unwell, not eating and that she was referred for a blood test.

84. So did Dr Dighton inform Patient A’s GP about her illness and the investigations he was undertaking? The Tribunal had regard to the possibilities of what took place:

1. Dr Dighton did not inform Patient A’s GP;
2. Dr Dighton informed Patient A’s GP verbally, by calling or speaking to them face to face - but this was not noted in Patient A’s medical records by either the GP or Dr Dighton;
3. Dr Dighton informed Patient A’s GP in writing, by letter, email or other form of written communication - but this was not noted in Patient A’s medical records by either the GP or Dr Dighton.

85. Both Patient A’s GP and Dr Dighton referred Patient A for blood tests. Patient A then went back to her GP on 21 December 2016 and there was no mention of the GP having heard from Dr Dighton in the intervening period. There was nothing in Dr Dighton’s handwritten record to the effect that he would write to Patient A’s GP.

86. Dr Dighton and Patient A’s GP were both consulting with Patient A and both appear to have been oblivious to each other’s activities regarding this patient. This is emphasised by the fact that both wrote up for investigations that were overlapping, namely the blood tests.

87. The Tribunal was of the view that the ‘failure’ is different in this instance given that Patient A was being actively investigated at this time for weight loss and other symptoms attached to that. This was a live issue for Patient A’s GP in December 2016 and, if any communications had been received, this would have been reflected in the GP notes given the concerns prompting the investigations for a possible serious illness.

88. The Tribunal considered why this was a failure on Dr Dighton’ part. It took account of Dr D’s conclusions in her expert report dated 28 September 2018:

"13/10/2016 - There is no record that Dr Dighton communicated with Patient A’s General Practitioner on 13/10/2016. In my opinion Dr Dighton should have communicated with Patient A’s General Practitioner about her illness and the investigations he was performing so that her General Practitioner was informed and could manage her safely. In my opinion by not communicating with Patient A’s General Practitioner, Dr Dighton put Patient A at increased risk of inappropriate diagnoses and treatments due to relevant clinical information not being available to either of them..."
89. The Tribunal found paragraphs 4(b)(i) and (ii) of the Allegation proved.

**Paragraph 6**

**Paragraph 6(f)(i)**

90. The Tribunal considered whether, between 5 January 2017 to 10 October 2017, Dr Dighton issued the prescriptions set out in Schedules 1 to 5 without regularly assessing Patient A’s mental state and suicide risk.

91. The Tribunal noted that Dr Dighton’s clinical notes are sparse and there is no evidence of regular assessment. The absence of evidence is, in this instance, evidence because of the regularity of his prescribing. He should have either been assessing Patient A’s mental state regularly or making a referral to mental health services and reflecting the same in her medical notes.

92. According to the evidence provided to the Tribunal, Dr Dighton prescribed the following medications to Patient A between 5 January 2017 and 10 October 2017:

- Co-proxamol 1600 tablets;
- Diazepam 604 tablets;
- Zolpidem 588 tablets;
- Mirtazapine 240 x 45mg tablets and 392 x 15mg tablets;
- Dihydrocodeine 1274 tablets.

93. The Tribunal considered whether Dr Dighton’s pattern of prescribing had the hallmark of issuing repeat prescriptions without regularly assessing Patient A’s mental state and suicide risk.

94. The Tribunal had regard to the possibilities of what took place:

1. Dr Dighton did regularly assess Patient A but did not record it;
2. Dr Dighton did regularly assess Patient A but recorded it elsewhere than in the notes before the Tribunal;
3. Dr Dighton did not assess Patient A regularly.

95. The Tribunal noted the need to regularly assess Patient A’s mental state and suicide risk given the medication he was prescribing to her. Dr D’s evidence was that this would require a more in depth assessment. Patient A had a number of related psychiatric conditions, namely complex pain syndrome, PTSD, depression, and prescription drug dependency. Patient A was particularly vulnerable.

96. The Tribunal also had regard to Patient A’s GP records where it referenced, on 10 September 2012, Patient A having attempted to overdose. Dr D acknowledged
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in her evidence that the combination of several psychiatric conditions put Patient A at an increased risk of suicide.

97. Patient A’s increased suicide risk made it even more important that Dr Dighton regularly assessed her mental state and suicide risk. Dr Dighton did not regularly assess Patient A’s mental state and suicide risk. The Tribunal found paragraph 6(f)(i) of the Allegation proved.

**Paragraph 6(f)(ii)**

98. The Tribunal considered whether, between 5 January 2017 to 10 October 2017, Dr Dighton issued the prescriptions set out in Schedules 1 to 5 without regularly appropriately referring Patient A to mental health services.

99. Prescriptions were issued in the relevant timeframe before a referral took place on 23 June 2017. The Tribunal had regard to Dr Dighton’s handwritten record on 10 October 2016 where he noted that there was no need for psychiatric referral. The Tribunal has inferred that there was no referral in the intervening eight months.

100. On 23 June 2017 when Dr Dighton did refer Patient A to a psychiatrist, Dr G, it was not for an assessment but for an opinion about her usage of medication. Prior to 23 June 2017, in conjunction with Dr Dighton’s record on the controlled drug patient management report dated 10 August 2017, he noted that he had made two referrals to mental health, one on 16 August 2012, and another on 23 June 2017. This is evidence that in the interim he made no referrals and yet continued to prescribe large quantities of medication.

101. The Tribunal also noted that in Dr Dighton’s referral letter to Dr G on 23 June 2017, although he was prescribing Patient A with antidepressants, he makes no reference to Patient A’s depression or any assessment he has made of her. On 31 August 2017 Dr Dighton, in an email, records "her sedative drugs were the primary reason for referral at the time". Dr D gave evidence that the referral on 23 June 2017 was an appropriate referral. However, the Tribunal noted the repeat prescriptions issued prior to that date.

102. It was an appropriate referral for a review of Patient A’s medication but, looking at Dr H letter in response to Dr Dighton, there was a diagnosis of four significant conditions (severe depression, PTSD, shoulder pain and drug dependency), which Dr Dighton neither noted in his consultations nor included in his letter of referral. This could have been completed by including a full patient history or drug history. Dr Dighton also omitted to mention co-proxamol in the referral letter. It would have been appropriate given the quantity of medication that Dr Dighton was prescribing, for Patient A to have been referred to mental health services much earlier in 2017 for assessment of her mental health, not merely her drug usage. The Tribunal found paragraph 6(f)(ii) of the Allegation proved.
Paragraph 6(f)(iii)

103. The Tribunal considered whether, between 5 January 2017 to 10 October 2017, Dr Dighton issued the prescriptions set out in Schedules 1 to 5 without informing Patient A’s GP.

104. The Tribunal determined that, on the balance of probabilities, Dr Dighton did not inform Patient A’s GP of the prescriptions issued. The Tribunal found paragraph 6(f)(iii) of the Allegation proved.

The Tribunal’s Overall Determination on the Facts

105. The Tribunal has determined the facts as follows:

That being registered under the Medical Act 1983 (as amended):

1. On 1 November 2011 you consulted with Patient A and you:
   a. failed to obtain an adequate medical history in that you did not ask Patient A about their:
      i. past medical history, including whether Patient A had any previous serious illnesses or operations;  
      Deleted after a successful Rule 17(2)(g) application
      ii. current medication;  
      Deleted after a successful Rule 17(2)(g) application
   b. prescribed lorazepam to Patient A when it is not clinically indicated for the treatment of vertigo;  
      Determined and found proved
   c. failed to inform Patient A’s GP that you had issued Patient A with a prescription for:
      i. Stemetil;  
      Determined and found proved
      ii. lorazepam.  
      Determined and found proved

2. On one or more occasion between 1 November 2011 and 10 October 2016 you:
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a. prescribed the following medications to Patient A:
   i. zolpidem;  
      Admitted and found proved
   ii. diazepam; 
      Admitted and found proved
   iii. dihydrocodeine; 
      Admitted and found proved
   iv. mirtazapine; 
      Admitted and found proved
   v. co-proxamol; 
      Admitted and found proved

b. failed to inform Patient A’s GP that you had prescribed the medications set out at paragraphs 2(a)(i) to (v) to Patient A. 
   Determined and found proved in relation to paragraph 2(a)(iii) and (iv) 
   Not proved in relation to paragraph 2(a)(i), (ii) and (v)

3. On 10 October 2016 you consulted with Patient A and you failed to:

a. obtain an adequate medical history in that you did not ask Patient A about:
   i. their mood; 
      Deleted after a successful Rule 17(2)(g) application
   ii. their anxiety levels; 
      Deleted after a successful Rule 17(2)(g) application
   iii. their sleep; 
      Deleted after a successful Rule 17(2)(g) application
   iv. their eating; 
      Deleted after a successful Rule 17(2)(g) application
   v. their concentration; 
      Deleted after a successful Rule 17(2)(g) application
   vi. any evidence of features of hallucinations or delusions; 
      Deleted after a successful Rule 17(2)(g) application
b. inadequately assess and examine Patient A in that you did not:

i. ask Patient A regarding pain control;  
   Deleted after a successful Rule 17(2)(g) application

ii. assess Patient A’s:

   aa. mood;  
   Deleted after a successful Rule 17(2)(g) application

   ab. speech;  
   Deleted after a successful Rule 17(2)(g) application

   ac. anxiety levels;  
   Deleted after a successful Rule 17(2)(g) application

   ad. communication;  
   Deleted after a successful Rule 17(2)(g) application

   ae. suicidal ideation;  
   Deleted after a successful Rule 17(2)(g) application

e. implement an adequate and appropriate treatment plan in that you did not adequately assess and examine Patient A as set out at paragraphs 3(b)(i) to (ii) above before deciding not to change their medication or refer them to a psychiatrist;  
 Deleted after a successful Rule 17(2)(g) application

d. keep an adequate record in that you did not record your assessment and examination of Patient A as set out at paragraphs 3(b)(i) to (ii);  
 Admitted and found proved

e. inform Patient A’s GP of the medications that you were prescribing to her every two weeks.  
 Determined and found proved

4. On 13 October December 2016 you consulted with Patient A and you failed to:
a. obtain an adequate medical history in that you did not ask Patient A about any other symptoms, including:

i. stomach upset;
Deleted after a successful Rule 17(2)(g) application

ii. vomiting;
Deleted after a successful Rule 17(2)(g) application

iii. abdominal pain;
Deleted after a successful Rule 17(2)(g) application

iv. bowel disturbance;
Deleted after a successful Rule 17(2)(g) application

v. bladder symptoms;
Deleted after a successful Rule 17(2)(g) application

vi. weight loss;
Deleted after a successful Rule 17(2)(g) application

b. inform Patient A’s GP about:

i. Patient A’s illness;
Determined and found proved

ii. the investigations you were performing.
Determined and found proved

5. Between 24 July 2017 and 10 October 2017:

a. you issued the prescriptions for mirtazapine on the occasions set out in Schedule 1 to Patient A;
Admitted and found proved

b. the prescriptions as referred to at paragraph 5(a) above were excessive in that:

i. they were issued at intervals of between seven to 15 days;
Admitted and found proved

ii. Patient A could have exceeded the maximum daily dose of 45mg.
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Admitted and found proved

6. Between 5 January 2017 and 10 October 2017:

a. you issued the prescriptions for co-proxamol on the occasions set out in Schedule 2 to Patient A; and

Admitted and found proved

b. when issuing the prescriptions referred to at paragraph 6(a) you failed to:

   i. adequately assess Patient A’s pain; 
   Deleted after a successful Rule 17(2)(g) application

   ii. try alternative painkillers; 
   Deleted after a successful Rule 17(2)(g) application

   iii. explain the risks of taking co-proxamol to Patient A; 
   Deleted after a successful Rule 17(2)(g) application

   iv. explain that co-proxamol was unlicensed to Patient A; 
   Deleted after a successful Rule 17(2)(g) application

   v. monitor the frequency of the prescriptions issued; 
   Admitted and found proved

b. c. the prescriptions as referred to at paragraph 6(a) above were excessive in that:

   i. the interval between one or more of those prescriptions was too short in order for Patient A to be taking co-proxamol according to the prescribed dose of one tablet four times daily and/or one tablet three times daily; 
   Admitted and found proved

   ii. you failed to restrict the number of tablets provided to Patient A to the dose you had prescribed; 
   Amended under Rule 17(6)

   e. d. you issued the prescriptions for zolpidem on the occasions set out in Schedule 3 to Patient A, which was excessive in that the intervals between those prescriptions suggested that Patient A was exceeding the recommended dose of 10mg daily; 
Admitted and found proved
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de. e. you issued the prescriptions for dihydrocodeine on the occasions set out in Schedule 4, which were excessive in that the intervals between those prescriptions suggested that Patient A was exceeding the prescribed dose of one tablet three times daily;
Admitted and found proved

d. f. you issued the prescriptions set out in Schedules 1 to 5 without:
   i. regularly assessing Patient A’s mental state and suicide risk;
      Determined and found proved
   ii. appropriately referring Patient A to mental health services;
      Determined and found proved
   iii. informing Patient A’s GP;
      Determined and found proved
   iv. adequate expertise to do so.
      Admitted and found proved

7. You failed to keep an adequate record in that you did not record:

a. between 1 November 2011 and 5 January 2017 any:
   i. mental health issues;
      Admitted and found proved
   ii. assessment of Patient A’s mental health;
      Admitted and found proved

b. why the following medications were prescribed to Patient A:
   i. co-proxamol;
      Admitted and found proved
   ii. dihydrocodeine;
      Admitted and found proved
   iii. mirtazapine;
      Admitted and found proved
   iv. diazepam;
      Admitted and found proved
v. zolpidem;  
**Admitted and found proved**

c. all of your interactions with Patient A between 1 November 2011 and 10 October 2017 during which you:

i. discussed or monitored Patient A’s clinical care;  
**Admitted and found proved**

ii. issued a prescription for the medications set out at paragraphs 7(b)(i) to (v).  
**Admitted and found proved**

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct.  
**To be determined**

**Determination on Impairment - 14/03/2019**

1. 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 Dighton’s fitness to practise is impaired by reason of misconduct.

**The Evidence**

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received further evidence as follows.

3. On behalf of the GMC the Tribunal received the determination of the GMC Investigation Committee dated 22 July 2016, which directed that a warning be issued on Dr Dighton’s registration.

4. The Tribunal also received a bundle of documentation in support of Dr Dighton including Continuing Professional Development (CPD) certificates and correspondence from Dr Dighton’s legal representatives to the GMC dated 6 February 2019 offering undertakings. An email dated 11 February 2019 was also included, from Professor I, Professor of Public Health and Honorary Consultant Cardiologist Director of Imperial Centre for Cardiovascular Disease Prevention, regarding an audit of ten of Dr Dighton’s recent cases.

**GMC Submissions**
5. Ms Dudley-Jones, Counsel, on behalf of the GMC, submitted that the facts admitted and found proved in this case amount to serious misconduct, and that Dr Dighton’s fitness to practice is currently impaired as a result of that serious misconduct.

6. In determining impairment, Ms Dudley-Jones invited the Tribunal to consider the criteria set out by Dame Janet Smith in the Fifth Shipman Report, which are as follows:

"Do our findings of fact ... show that his/her fitness to practise is impaired in the sense that s/he:

a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession
d. has in the past acted dishonestly and/or is liable to act dishonestly in the future."

7. Ms Dudley-Jones further invited the Tribunal to consider the case of CHRE v NMC and Grant [2011] EWHC 927, in which Mrs Justice Cox set out that:

"... it is essential, when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations emphasised at the outset of this section ... namely the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession."

8. Ms Dudley-Jones submitted that Dr Dighton failed to meet the standards set out in GMP, as well as the standards set out in the GMC’s guidance on prescribing. She submitted that Dr Dighton was a senior practitioner at the time of the events, and was well aware of his responsibilities and obligations towards Patient A. She further submitted that Dr Dighton was well aware that Patient A was a complex patient; despite this, he issued and reissued prescriptions to a patient he knew to be vulnerable, severely depressed, and addicted, despite not having the relevant expertise to do so. Ms Dudley-Jones described Dr Dighton’s record keeping in respect of Patient A as "nothing short of appalling", submitting that this record keeping further compounded his prescribing failures.

9. Ms Dudley-Jones submitted that there were a number of aggravating factors relating to impairment, as follows:

- The period of time Dr Dighton prescribed the medications to Patient A;
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- His failure to inform Patient A’s GP of his prescribing;
- The fact that his actions could easily have been avoided - Ms Dudley-Jones submitted that Dr Dighton did not have to prescribe to Patient A, and could instead have left it to her GP;
- The combination of drugs he prescribed to Patient A;
- The fact that he had previously been warned not to prescribe benzodiazepines to patients on a long-term basis.

10. With regard to this last point, Ms Dudley-Jones invited the Tribunal to consider the determination from Dr Dighton’s July 2016 GMC Investigation Committee hearing. She submitted that Dr Dighton’s failures in respect of Patient A began in 2011, and that mid-way through his period of prescribing to Patient A he was issued with a warning in respect of two different patients in circumstances Ms Dudley-Jones described as "practically identical". This, she submitted, must go to Dr Dighton’s insight.

11. Ms Dudley-Jones further submitted that Dr Dighton was not present for the majority of stage 1 of this hearing, and none of stage 2; she submitted that this was indicative of a ‘cavalier’ approach to these proceedings.

12. Ms Dudley-Jones submitted that Dr Dighton’s failings are capable of remediation, but submitted that this Tribunal has been provided with very little evidence of remediation, and accordingly, could not be satisfied that his misconduct would not be repeated. Ms Dudley-Jones submitted that, in all the circumstances of this case, Dr Dighton’s actions both individually and cumulatively amount to serious misconduct. Accordingly, she invited the Tribunal to find that Dr Dighton’s fitness to practice is currently impaired as a result of that serious misconduct.

13. Following Mr Brassington’s submissions, Ms Dudley-Jones confirmed that the GMC received proposed undertakings from Dr Dighton in February of this year. She confirmed that these undertakings were not accepted, but submitted that the GMC would carefully look at any further proposed undertakings offered by Dr Dighton at sanction stage (should impairment be found).

Submissions on Dr Dighton’s behalf

14. Mr Brassington invited the Tribunal to consider three questions when considering impairment:

   1. Is the conduct capable of being remediated?
   2. Has it been remediated?
   3. What is the risk of repetition, looking forward?

15. Mr Brassington invited the Tribunal to consider Dr Dighton’s current role. He submitted that it was clear from Dr Dighton’s proposed undertakings that he no
longer undertakes General Practice work, and that he has not prescribed drugs (save for Dobutamine) since December of last year.

16. Mr Brassington submitted that Dr Dighton’s absence is not indicative of a ‘cavalier’ approach to these proceedings. He informed the Tribunal that Dr Dighton is currently otherwise engaged with pre-existing matters of practice and administration which could not be moved. He reminded the Tribunal that there was no ‘compulsion’ on anyone to give evidence, and rejected Ms Dudley-Jones’ submissions with regard to record-keeping.

17. Turning to insight, Mr Brassington reminded the Tribunal that Dr Dighton made ‘serious’ admissions at the outset of this hearing. He described this case as revolving around Dr Dighton acting beyond his area of expertise. The Tribunal heard that, having reflected on his failings, Dr Dighton no longer accepts or treats any patients as a GP, instead focusing solely on his cardiac investigation work.

18. In respect of remediation, Mr Brassington took the Tribunal through Dr Dighton’s CPD documentation, drawing particular attention to those courses relating to record-keeping and advanced medicine. Addressing the three questions he invited the Tribunal to consider at the outset of his submissions, Mr Brassington submitted that there was no risk of repetition looking forward, given the undertakings offered by Dr Dighton and the manner in which he has already limited his practice in line with those undertakings.

19. In respect of the public interest, Mr Brassington submitted that a finding of impairment on the basis of public interest alone was not warranted in the circumstances of this case.

The Relevant Legal Principles

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

21. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first whether the facts as found proved amounted to misconduct, and then whether the doctor’s fitness to practise is currently impaired by reason of that misconduct.

22. The Tribunal must determine whether Dr Dighton’s fitness to practise is impaired today, taking into account Dr Dighton’s 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.
23. The Legally Qualified Chair stated that there is clear authority that, when determining the issue of impairment of fitness to practise, the question is whether it is impaired as at the date of the hearing (i.e. today). Accordingly, regard must be had for the way in which the practitioner has acted, or failed to act, in the past, including the facts found proved by the Tribunal. In this regard the Tribunal is reminded of the following as set out in *Meadow v GMC* [2006] EWCA Civ 1390:

"The purpose of FTP proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FTP Tribunal thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past."

24. The Tribunal was invited to have regard for the guidance of Silber J. in *Cohen v GMC* [2008] EWHC 581 Admin, that any approach to the issue of whether a Doctor’s fitness to practise is to be regarded as "impaired" must take account of the need to give substantial weight to the public interest, including the protection of patients, the maintenance of public confidence in the profession and declaring and upholding proper standards of conduct and behaviour.

**The Tribunal’s Determination on Impairment**

**Misconduct**

25. The Tribunal first considered whether Dr Dighton’s actions amount to misconduct.

**Paragraph 1(b)**

26. The Tribunal has found that, on 1 November 2011, Dr Dighton consulted with Patient A and prescribed lorazepam to her when it was not clinically indicated for the treatment of vertigo. The Tribunal found this true as a fact given that lorazepam is not clinically indicated for vertigo. However, the Tribunal had received no evidence that Dr Dighton prescribed lorazepam to treat Patient A’s vertigo.

27. The Tribunal noted that Patient A had received lorazepam for anxiety from her GP in the relevant time period. Dr Dighton’s handwritten record of his consultation with Patient A on 1 November 2011 was so sparse, it was unclear why he prescribed lorazepam.

28. The Tribunal noted Dr D’s view that if he prescribed lorazepam for another reason such as anxiety but failed to record that as the reason, and if there was an indication for prescribing it, then Dr Dighton’s action did not fall below the standard expected. The Tribunal determined that it was plausible that the lorazepam was being
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prescribed by Dr Dighton for Patient A’s anxiety in a similar manner to the GP. The
Tribunal therefore concluded that Dr Dighton’s actions in this regard did not amount to
misconduct.

Paragraph 1(c)(i) and (ii)

29. The Tribunal has found that, on 1 November 2011, Dr Dighton consulted with
Patient A and failed to inform her GP that he had issued a prescription for stemetil and
lorazepam. The Tribunal considered this to be an issue in relation to the need to
maintain continuity of care. It noted that Dr Dighton was treating Patient A without a
referral and without communicating with her GP in a non-emergency situation.

30. The Tribunal had regard to Dr D’s opinion in her expert report dated
28 September 2018, that Dr Dighton’s actions:

“fell below the standard expected of a reasonably competent GP because Patient
A would be put at risk of adverse effects if Dr Dighton or Patient A’s GP
prescribed without knowing her other medications but not seriously below
because these medications were short term and relatively harmless in short
courses.

Good Practice in Prescribing Medicines 2008 says:
8. If you are not the patient’s general practitioner and you accept a patient for
treatment without a referral from the patient’s general practitioner, then you
must:
(a) explain to the patient the importance and benefits of keeping their general
practitioner informed
(b) inform the patient’s general practitioner, unless the patient objects
(c) where possible, inform the patient’s general practitioner before any treatment
is started, unless the patient objects to this disclosure.
9. If the patient does not want their general practitioner to be informed, or has
no general practitioner, then you must:
(a) take steps to ensure that the patient is not suffering from any medical
condition or receiving any other treatment that would make the prescription of an
medicines unsuitable or dangerous
b) take responsibility for providing all necessary aftercare for the patient until
another doctor agrees to take over.”

31. The Tribunal noted that this was the first occasion that Dr Dighton had a
consultation with Patient A and he was obliged to record that consultation and where
possible communicate to her GP which drugs he had prescribed. There is a presumption
that a resident of England has a GP unless there are reasons to assume otherwise. It
was a non-emergency situation and he should have informed the GP for the benefit of
Patient A. It is the start of a potentially attitudinal issue that, from the outset,
Dr Dighton made a poor record of his first consultation with Patient A and did not inform
her GP or record a reason for not doing so. It suggests he regarded such requirements as a low priority. In the light of the expert opinion and in isolation, the Tribunal concluded that this did not meet the threshold to amount to misconduct.

**Paragraph 2(a)(i) to (v)**

32. The Tribunal noted that this paragraph of the Allegation has not been charged as a failure on Dr Dighton’s part and alleges a fact which Dr Dighton admits that he prescribed a number of medications to Patient A between 1 November 2011 and 10 October 2016. The Tribunal concluded that Dr Dighton’s actions did not amount to misconduct.

**Paragraph 2(b) in relation to paragraph 2(a)(iii) and (iv)**

33. The Tribunal has found that Dr Dighton failed to inform Patient A’s GP that he prescribed dihydrocodeine and mirtazapine to Patient A on one or more occasions between 1 November 2011 and 10 October 2016. The Tribunal considered this to be an issue relating to Patient A’s continuity of care.

34. The Tribunal was of the view that Dr Dighton placed Patient A at risk as he was prescribing dihydrocodeine and mirtazapine as part of a cocktail of drugs prescribed by both Dr Dighton and Patient A’s GP over a five year period. The GP had no knowledge of Dr Dighton’s prescribing of dihydrocodeine or mirtazapine. The GP was also concurrently prescribing dihydrocodeine, which is associated with drug dependence as it has addictive properties.

35. Dr Dighton was prescribing mirtazapine, which is an antidepressant. Patient A’s GP was managing her mental health and referring her to secondary psychiatric services during this period but was unaware of Dr Dighton’s prescribing of antidepressants.


37. It was to the detriment of Patient A that the mental health professionals, who had consultations with her, had no knowledge of the prescriptions she was being issued for dihydrocodeine and mirtazapine from Dr Dighton as he had not informed Patient A’s GP. The Tribunal determined that Dr Dighton’s actions were sufficiently below the standards of conduct reasonably to be expected of a doctor as to amount to misconduct.

**Paragraph 3(d)**
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38. Dr Dighton admitted this paragraph of the Allegation that, on 10 October 2016, he consulted with Patient A and failed to keep an adequate record in that he did not record his assessment and examination of Patient A.

39. Dr Dighton’s record of the consultation with Patient A on 10 October 2016 was:

"Stable on drug dose - regulated to every 2/52
Prognosis: post-op should no longer need medication
Discussed with her and husband
No need for psychiatric referral
To monitor closely”

40. At that time, by his own admission, Dr Dighton was prescribing zolpidem, dihydrocodeine, mirtazapine, co-proxamol and diazepam to Patient A.

41. The Tribunal determined that it was not possible to discern from Dr Dighton’s record what sort of assessment took place and how he could know what progress or change there may have been at the next consultation, which he records as taking place on 13 December 2016. This was of particular importance given that Dr Dighton was prescribing an antidepressant to Patient A and was supposedly monitoring her mental state and suicide risk closely. Assessing these is a patient safety issue. There is no reference to any assessment or monitoring to ensure that Patient A’s medical needs were being addressed.

42. The consequences of Dr Dighton’s poor record keeping are exemplified by the expert setting out her opinion in the alternative, repeatedly, in her report: “if he did assess but failed to record it…… if he did not assess……” Good record keeping is fundamental to good practice and continuity of care between different practitioners and for the recognising of trends in a patient’s medical needs. From 12 April 2012 when Dr Dighton spoke to Patient A’s GP, he clearly knew that she had a GP.

43. The Tribunal noted that the need to maintain good record keeping is fundamental to a doctor’s practice. It was important in order to ensure continuity of care and to avoid unnecessary risks to the patient. The Tribunal determined that Dr Dighton’s failure to keep an adequate record on 10 October 2016 did amount to misconduct.

Paragraph 3(e)

44. The Tribunal has found that, on 10 October 2016, Dr Dighton consulted with Patient A and failed to inform Patient A’s GP of the medications that he was prescribing to her every two weeks.

45. The Tribunal had regard to Dr D’s opinion in her expert report dated 28 September 2018:
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"If Dr Dighton did not communicate with Patient A’s GP regarding the prescriptions he had issued then in my opinion his actions fell seriously below the standard expected of a reasonably competent general practitioner because Patient A would be put at risk of adverse effects if Dr Dighton or Patient A’s GP prescribed without knowing her other medications especially given the nature of the medications prescribed."

46. The Tribunal accepted the opinion of the expert and accordingly concluded that Dr Dighton’s actions did amount to misconduct.

Paragraph 4(b)(i) and (ii)

47. The Tribunal has found that, on 13 December 2016, Dr Dighton consulted with Patient A and failed to inform Patient A’s GP about Patient A’s illness and the investigations he was performing.

48. The Tribunal had regard to Dr D’s opinion in her expert report dated 28 September 2018:

"by not communicating with Patient A’s General Practitioner, Dr Dighton put Patient A at increased risk of inappropriate diagnoses and treatments due to relevant clinical information not being available to either of them, and his actions therefore fell below the standard expected of a reasonably competent general practitioner but not seriously below because Patient A was not acutely or seriously unwell."

49. The Tribunal noted in Annex D that the date of Dr Dighton’s consultation with Patient A in his handwritten record of ‘13.10.16’ was unclear and the month denoted as ‘10’ could be a ‘12’. As a result of the Tribunal’s observations regarding concurrent GP records, both parties accepted that the date should be ‘13.12.16’ and amendment to that part of the Allegation is set out in the Tribunal’s determination on the facts at paragraph 13.

50. Dr D observed that Dr Dighton’s failure to inform the GP about the consultation was not seriously below as Patient A was not acutely or seriously unwell. Dr D expressed her view, in her expert report, when the date of that consultation was still believed to be October 2016. That date was amended to December, subsequent to the expert giving oral evidence. The Tribunal noted that the concurrent GP records for December indicate that Patient A was acutely unwell. On 12 December 2016, the GP plan was:

"in view of weight loss to have urgent bloods and urgent USS... Patient was very aggressive today shouting in waiting room and during consult - Shouting and asking for medication to calm her down. i advised in view of her history with opiates this is not encouraged but i explained i will make arrangements for her
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symptoms to be investigated quickly. pt [patient] left room in middle of consult screaming.” (sic)

51. Under "History" the GP has recorded Patient A as "very anxious today, tearful feels she has lost 3 stone." Her weight was recorded as 10 stone 3 lbs.

52. The Tribunal determined that Dr Dighton’s failure to inform the GP of Patient A’s consultation with him on the next day, 13 December 2016, was seriously below the standards expected of a reasonably competent GP and concluded that his actions amounted to misconduct.

Paragraph 5(a)

53. Dr Dighton admitted this paragraph of the Allegation that, between 24 July 2017 and 10 October 2017, he issued prescriptions for mirtazapine as set out in Schedule 1.

54. The Tribunal had regard to a letter from Dr G, Consultant Psychiatrist, on 12 July 2017 who approved the use and dosage of mirtazapine. The Tribunal concluded that Dr Dighton’s actions did not amount to misconduct in this regard.

Paragraph 5(b)(i) and (ii)

55. Dr Dighton admitted paragraph 5(b)(i) and (ii). The Tribunal had regard to Dr D’s opinion in her expert report dated 28 September 2018:

"During the period 24/07/2017 to 10/10/2017 45mg tablets were being prescribed and 30 tablets were being supplied with each prescription. The prescription intervals were 7-15 days which would not have been prescribed by a reasonably competent general practitioner as Patient A could exceed the maximum daily dose. In my opinion Dr Dighton’s actions fell below the standard of a reasonably competent general practitioner during this period because Patient A was being treated for depression and she could have intentionally or accidentally overdosed on mirtazapine which could pose a serious risk to her health including death. His actions in respect of the mirtazapine were not seriously below because it was for a short period of time and was due to a mistake in the dose on the prescriptions which should not happen but can occasionally and was not intentionally reckless.”

56. Dr D has taken a narrow view regarding the prescribing of mirtazapine. The Tribunal takes a broader view that the period amounts to three and a half months at a time when mirtazapine was one of a cocktail of drugs. Large quantities of mirtazapine were prescribed and the frequency with which they were prescribed would lead to Patient A to having a far greater quantity available to her than was appropriate. Patient A was at risk of accidental overdose due to the quantity prescribed and in particular taking into consideration the amount of sedative drugs which Dr Dighton had also
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prescribed. The Tribunal concluded that Dr Dighton’s actions did amount to misconduct in this instance.

Paragraph 6(a)

57. Dr Dighton admitted this paragraph of the Allegation that, between 5 January 2017 and 10 October 2017, he issued prescriptions for co-proxamol as set out in Schedule 2.

58. The Tribunal had regard to the letter from Professor J, Consultant Orthopaedic Surgeon, to Patient A’s GP on 23 February 2012. Professor J advised the prescribing of co-proxamol. The GP prescribed co-dydramol instead.

59. The Tribunal also took account of the letter from Dr K, a pain consultant, who recommended that Patient A’s GP prescribe co-proxamol to Patient A on 3 April 2018.

60. The Tribunal do not find that Dr Dighton’s actions with regard to the prescribing of co-proxamol amounted to misconduct. The Tribunal accepted that, despite the risks associated with the prescribing of co-proxamol and its unlicensed status, the mere prescribing of it cannot be said to have amounted to misconduct.

Paragraph 6(b)(v) and 6(c)(i)

61. Dr Dighton admitted this paragraph of the Allegation that, between 5 January 2017 and 10 October 2017, when issuing the co-proxamol prescriptions he failed to monitor their frequency and the prescriptions were excessive.

62. The Tribunal noted the document attached to Dr D’s expert report entitled ‘MHRA withdraws the pain killer co-proxamol’:

"A phased withdrawal of the commonly prescribed painkiller, co-proxamol, was announced today by the Medicines and Healthcare products Regulatory Agency.

A recent consultation looking at evidence for the safety and effectiveness of co-proxamol found that the benefits of the medicine did not outweigh the risks and that it should be gradually withdrawn from clinical use. Co-proxamol is associated with 300-400 intentional and accidental fatal overdoses each year."

63. The Tribunal had regard to the need to monitor the frequency of prescriptions as co-proxamol is known to be fatal in overdose. The Tribunal noted that Dr Dighton was, throughout this period of time, prescribing another medication, dihydrocodeine, a strong opiate painkiller in excessive quantities and at shorter intervals than the prescribed dose required.
64. Dr Dighton admitted failing to monitor the frequency of the prescriptions of co-proxamol he issued. The Tribunal concluded that Dr Dighton’s actions were sufficiently below the standards expected of a doctor to amount to misconduct.

Paragraph 6(d)

65. Dr Dighton admitted this paragraph of the Allegation that, between 5 January 2017 and 10 October 2017, he issued the prescriptions for zolpidem to Patient A as set out in Schedule 3 and the prescriptions were excessive.

66. The Tribunal had regard to Dr D’s opinion in her expert report dated 28 September 2018:

“Zolpidem are known to cause dependency and tolerance and the amount supplied to patients should be monitored to stop this happening. In my opinion, Dr Dighton’s actions in prescribing more than the recommended maximum dose of zolpidem to Patient A were below the standard expected of a reasonably competent general practitioner as it should have been obvious from the prescription intervals that she was taking above the recommended dose and this put her at risk of dependency and dose escalation, but not seriously below as increasing the dose to 2 at night was unlikely to result in serious harm.”

67. The Tribunal took account of Dr Dighton’s letter to Patient A’s GP in April 2012 in which he informed the GP that he should be the sole prescriber for zolpidem.

68. The Tribunal accepted the expert opinion and concluded that, in isolation, Dr Dighton’s actions did not amount to misconduct.

Paragraph 6(e)

69. Dr Dighton admitted this paragraph of the Allegation that, between 5 January 2017 and 10 October 2017, he issued the prescriptions for dihydrocodeine to Patient A as set out in Schedule 4 and the prescriptions were excessive.

70. The Tribunal had regard to Dr D’s opinion in her expert report dated 28 September 2018, that Dr Dighton’s actions fell below the standard expected of a reasonably competent GP. She stated that Dr Dighton’s actions were not seriously below the expected standard because the doses were not escalating.

71. At the same time, Patient A was obtaining dihydrocodeine from her GP. Dr Dighton had not informed the GP that he was prescribing this drug to Patient A. In all the circumstances, the Tribunal determined that, in isolation, Dr Dighton’s actions did not amount to misconduct.

Paragraph 6(f)(i) to (iii)
72. The Tribunal has found that, between 5 January 2017 and 10 October 2017, Dr Dighton issued the prescriptions set out in Schedules 1 to 5 without regularly assessing Patient A’s mental state and suicide risk, appropriately referring her to mental health services or informing her GP.

73. The Tribunal had regard to Dr D’s opinion in her expert report dated 28 September 2018 that, if Dr Dighton did not regularly assess Patient A, appropriately refer her, or inform her GP, then his actions fell seriously below the expected standard.

74. Dr Dighton’s failings fell sufficiently below the standard to be expected of a GP. The Tribunal concluded that Dr Dighton’s failings did amount to misconduct.

Paragraph 6(f)(iv)

75. Dr Dighton admitted this paragraph of the Allegation that, between 5 January 2017 and 10 October 2017, he issued the prescriptions in Schedules 1 to 5 without adequate expertise to do so.

76. Patient A had complex medical needs. The oral evidence from the expert, Dr D, was that her needs would have challenged an experienced GP. Dr Dighton took on the management of Patient A without a referral from the GP. Dr Dighton made only two referrals to psychiatrists. The first, on 16 August 2012, to Dr AM to which he received no reply and which he did not follow up. Secondly, on 23 June 2017, he made a referral to Dr G. He made no other secondary psychiatric referrals between 2011 and 2017. Dr Dighton is not a GP by training. He has admitted that he lacked the adequate expertise to prescribe these drugs to Patient A. All doctors need to limit their scope of practice within their expertise. This patient was at the high end of complexity with a risk of fatal overdose, either intentionally or accidentally. The Tribunal had a serious concern regarding Dr Dighton’s competency in this regard. The Tribunal concluded that Dr Dighton’s actions did amount to misconduct.

Paragraph 7(a) to (c)

77. Dr Dighton admitted this paragraph of the Allegation that he failed to keep an adequate record as he did not record, between 1 November 2011 and 5 January 2017, mental health issues or assessment of Patient A’s mental health. Further, that Dr Dighton did not keep an adequate record of why a number of medications were prescribed to Patient A or of all of his interactions with Patient A between 1 November 2011 and 10 October 2017.

78. The Tribunal had regard to Dr Dighton’s handwritten records of his consultations with Patient A in the relevant time period. It noted that there were five entries of consultations between the five years from November 2011 to January 2017 which did not even cover two sides of a single A4 page.
79. During that time Dr Dighton was prescribing a significant range of sedatives, painkillers and antidepressants to Patient A, many of which had addictive properties and could be fatal in overdose. Patient A’s medical history is not set out in any of the entries. There is no note of her current medication, either prescribed by the GP or by Dr Dighton. The Tribunal found Dr Dighton’s records to be appalling. Good record keeping is fundamental for the continuity of care between doctors and within a doctors own practice, for a longitudinal view of a patient.

80. The Tribunal had regard to Dr D’s opinion in her expert report dated 28 September 2018:

"In my opinion if Dr Dighton was discussing clinical care with Patient A and providing regular medication from 01/11/2011 to 10/10/2017 then he should have recorded these contacts and not to do so was seriously below the standard expected of a reasonably competent general practitioner because he was providing private prescriptions for a combination of drugs with potential serious side effects such as dependency and overdose [and paragraphs 19 and 21 of GMP as listed below]."

81. The importance of record keeping is a fundamental principle of GMP. The Tribunal concluded that Dr Dighton’s failures in record keeping fell sufficiently below the standards to be expected of a GP that they amount to misconduct.

GMP

82. The Tribunal found that Dr Dighton has therefore breached the following paragraphs of GMP:

"1. Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.

14. You must recognise and work within the limits of your competence.

15. You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

   a. adequately assess the patient’s conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient
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b. promptly provide or arrange suitable advice, investigations or treatment where necessary

c. refer a patient to another practitioner when this serves the patient’s needs.

16. In providing clinical care you must:

a. prescribe drugs or treatment, including repeat prescriptions, only when the drugs or treatment serve the patient’s needs

b. provide effective treatments based on the best available evidence

... d. consult colleagues where appropriate

... 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

...

21. Clinical records should include:

a. relevant clinical findings

b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions

c. the information given to patients

d. any drugs prescribed or other investigation or treatment

...

44. You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:

a. share all relevant information with colleagues involved in your patients’ care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers

b. check, where practical, that a named clinician or team has taken over responsibility when your role in providing a patient’s care has ended. This may be particularly important for patients with impaired capacity or who are vulnerable for other reasons.”

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83. The Tribunal found that Dr Dighton’s actions amount to misconduct in relation to paragraphs 2(b), 3(d), 3(e), 4(b)(i) and (ii), 5(b)(i) and (ii), 6(b)(v), 6(c)(i), 6(f)(i) to (iv), and 7(a) to (c) of the Allegation. The Tribunal went on to consider whether Dr Dighton’s fitness to practise is currently impaired by reason of that misconduct.

84. The Tribunal has found that Dr Dighton breached a number of tenets of the medical profession, including the need to work within your own competence; to keep adequate records; and to work with colleagues in the best interests of your patient including in this case informing Patient A’s GP and keeping adequate records of his consultations.

85. The Tribunal had regard to whether, in principle, Dr Dighton’s conduct is remediable. It determined that, in principle, it is.

86. The Tribunal has considered what remediation has taken place since 2017 with regard to Dr Dighton’s insight, training and conduct.

87. To his credit, Dr Dighton made a number of admissions to the Allegation. He admitted to:

1. Having prescribed the listed drugs to Patient A between 2011 and 2017;
2. Failing to keep an adequate record between 2011 and 2017;
3. Issuing prescriptions for mirtazapine, zolpidem, co-proxamol and dihydrocodeine at too regular intervals such that Patient A could have exceeded the maximum dose;
4. Issuing prescriptions without the expertise to do so.

88. Dr Dighton also offered undertakings to the GMC prior to the start of this hearing in February 2019. The Tribunal concluded that this was, perhaps, an acknowledgement by Dr Dighton that there were areas of his practice that needed to be addressed. The Tribunal noted Dr Dighton’s undertakings are, to a large extent, restricting his practice to his area of current expertise which is a requirement for all doctors as set out in GMP.

89. The Tribunal have had regard to Dr Dighton’s record of relevant CPD and the observations of Professor I. The only relevant training that the Tribunal has found is a 1 hour course on ‘Medical Records in Primary Care’ on 23 April 2018 and a ‘Clinical Record Keeping Training Course’ on 16 February 2019. The Tribunal noted that the other CPD is more general in nature and is not focused on the issues in question. The Tribunal determined that this CPD only assisted it in a limited way, especially as Dr Dighton should have known of the requirements of good record keeping and the need to inform a patient’s GP.
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90.  Dr Dighton submitted an email dated 11 February 2019 from Professor I in respect of a 1 hour supervision session where ten cases, seen in the preceding ten days, in relation to cardiology were reviewed. This does not to relate to the allegations that the Tribunal considered.

91.  The Tribunal observed that there have been no complaints placed before it about Dr Dighton since 2017.

92.  The Tribunal took into consideration that Dr Dighton’s failings spanned a period of six years. Dr Dighton received a letter from the GMC of advice in December 2011 which included similar concerns to those considered by the Investigation Committee in July 2016 namely a failure to inform the GP of a prescribing regime and the repeated issuing of prescriptions without seeing patients face to face.

93.  In July 2016 the Investigation Committee of the GMC determined that Dr Dighton would be subject to a warning regarding two other patients. That warning concerned:

- concerns regarding failing to carry out a screening questionnaire to determine whether a patient was anxious or depressed;
- failure to refer patients to secondary psychiatric services;
- failure to devise a treatment plan;
- failure to inform GP of prescribing regime;
- repeated issuing of prescriptions without seeing patients face to face.

94.  The content of that warning in 2016 was:

"[Dr Dighton:] You prescribed benzodiazepine based drugs to two of your patients on a long term basis. You did not refer the patients to secondary psychiatric services. You failed to devise a treatment plan for the prescribing of the medication. You did not inform the patients’ NHS GP of your prescribing regime. On many occasions prescriptions were issued without seeing the patients face to face.

This conduct does not meet with the standards required of a doctor. It risks bringing the profession into disrepute and it must not be repeated."

95.  Whereas Dr Dighton made admissions to some of the Allegation, the paragraphs of the Allegation that Dr Dighton disputed were significant:

1.  Failing to inform Patient A’s GP about: his consultations with her, treatment of her and the prescribing of medications to her;
2.  Failing to assess Patient A’s mental state and suicide risk
3.  Failing to refer Patient A to mental health services.
96. Regrettably, the Tribunal has not heard evidence from Dr Dighton, nor received a statement from him, to assist it in gauging what level of insight he now has in regard to the matters which the Tribunal has found proved. The Tribunal makes neither adverse findings nor adverse assumptions due to Dr Dighton’s non-attendance. He is entitled not to provide this evidence. The Tribunal concluded that whilst the admissions show a level of insight, it does not accept that they are admissions to the gravamen of the case.

97. The Tribunal determined that, having received the letter of advice in 2011 and the warning in 2016, Dr Dighton’s conduct regarding Patient A demonstrated no insight whatsoever into his failings. Additionally, the Tribunal finds the records kept by Dr Dighton to have been appalling in relation to Patient A from 2011 to 2017. There is no evidence of reflective practice on Dr Dighton’s part. The Tribunal has to consider Dr Dighton’s current level of insight and concludes, in the light of the above, that it is minimal.

98. Mr Brassington submitted that the Tribunal can be confident that Dr Dighton will not repeat the previous failings of his practice as he is now restricting his work to non-invasive screening of adult cardiology patients. The Tribunal noted that it has received no evidence that Dr Dighton’s conduct has been remedied through training, or through a demonstration of insight and practice since 2017. The Tribunal accepted the GMC submission that Dr Dighton’s actions were a deliberate course of conduct over many years.

99. The Tribunal does not accept Mr Brassington’s submission that Dr Dighton presents no ongoing risk. The Tribunal has grave concerns given Dr Dighton’s sustained poor practice over a six year period, the advice letter in 2011 and the warning in 2016. In light of the above, the Tribunal determined that Dr Dighton’s lack of insight is intractable. In these circumstances he is unlikely to remediate and there is a material risk of repetition.

100. The Tribunal has therefore determined that Dr Dighton’s fitness to practise is impaired by reason of misconduct. It cannot be satisfied that the risk of repetition is low due to Dr Dighton’s minimal insight, his unfocused training, a lack of any apology and no reflective practice. Even if he had remediated, the Tribunal determined that a finding of impairment would still be required in order to uphold the GMC’s statutory overarching objective. Impairment is also and separately found in terms of the public interest, namely the maintenance of public confidence in the profession and the upholding of proper professional standards and conduct for members of the profession.

**Determination on Sanction - 29/10/2019**

1. Having determined that Dr Dighton’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 Evidence

2. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

3. At this stage of the hearing the Tribunal received two statements from Dr Dighton dated 29 March and 9 October 2019. It also received oral evidence from Dr Dighton at this stage.

4. Dr Dighton informed the Tribunal that since 18 December 2018 he had restricted his medical practice to non-invasive, diagnostic cardiology. He no longer practises as a GP and had varied the CQC registration of the Loughton Clinic to reflect that he now offers only a diagnostic cardiology service. His cardiac work is supervised by Professor I, Professor of Public Health at Imperial College. He stopped GP work on 18 December 2018 because of a discussion with a CQC advisor in October 2018 as he had impressed upon Dr Dighton that GP work was a specialty and that Dr Dighton’s experience was limited.

5. Dr Dighton asserted that he had 53 years’ of experience exercising his clinical judgement and had never received a single patient complaint. Dr Dighton informed the Tribunal that from 1982 he was a sole practitioner in a private practice. He has had contact with about 20,000 patients since 1982 of whom about two fifths came to him for his cardiac services and the rest for his GP services. In 2017 he had 20 patients on benzodiazepines who consulted with him as a GP. He was seeing five patients a day. Two would be cardiac and the others would be minor GP cases. He had no formal GP training. Asked about his training and experience in medication, he stated he would trial patients on drugs and build up experience from that. His knowledge and wisdom came from many years of experience in clinical roles, and his time in academia between 1973 and 1982. In his statement, he set out that his last postgraduate qualification was in 1973 when he became a member of the Royal College of Physicians.

6. Dr Dighton stated that, in the light of the significant issues in the charges determined by the Tribunal relating to his prescribing to Patient A, he had, over the course of 2018 worked in conjunction with Dr M, a GP, to move all of his patients off benzodiazepine medication and where that was not possible to transfer their care to another private GP or to a psychiatrist. Dr Dighton stated that he had been successful in that endeavour. He stated that he had resolved to no longer prescribe medication for patients but would wish to be able to administer medication in a life-threatening emergency.

7. Dr Dighton stated that he recognised that he had made errors ‘on judgment’ (sic) in relation to Patient A and that he did not have the experience that a doctor dealing with addictions would have had and which might have enabled him to
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appreciate what was happening. He also acknowledged that he did not make adequate notes and that had contributed to his failure to appreciate the true position. Dr Dighton apologised to the Council for his errors. He stated that he had been regularly appraised. He also stated that his clinic had been inspected by the CQC on two occasions and rated as ‘good’, overall.

8. Before the Tribunal, in relation to his treatment of Patient A, Dr Dighton stated that if he saw Patient A today he would not accept her as a patient. He stated that he would reject any patient with an addiction due to his lack of experience. He told the Tribunal that he had experience of drugs, in particular lorazepam, from his time working at Charing Cross Hospital in the 1970s. He told the Tribunal that his personal experience of patients using that medication long-term was contrary to the guidance contained within the British National Formulary (BNF). He stated, however, that he had no experience of dealing with addicted patients and their needs. He told the Tribunal that he had been ‘deceived by a clever and manipulative person’ [Patient A] and referred to the statement made by Patient A’s GP in which he had described her as aggressive. He informed the Tribunal that Patient A was a demanding person who had refused to see a psychiatrist. He stated that he should have denied her treatment and sent her back to her GP. Instead he felt sympathy towards her. She had not presented as aggressive in consultations with him and he had regard to the fact that she had been a nurse.

9. In 2011 Dr Dighton had been issued with a letter of advice from the GMC relating to his prescribing. In 2016 he appeared before the GMC’s Investigation Committee and he was issued with a warning relating to his prescribing of benzodiazepines. Dr Dighton stated that he did not accept that the matters which had brought him before this Tribunal indicated a wider pattern of poor, risky prescribing. He stated that the circumstances of each case related to different patients being treated with different drugs. He also stated that his academic knowledge of those drugs relating to work done in the 1970s had led him to view the use of them differently and he was trying to make an academic point. He accepted he had been warned that his conduct then was below standard. He denied in this instance any clinical wrongdoing and distinguished it from legal wrongdoing. He asserted that clinical wrongdoing meant the patient suffers but Patient A did not suffer. He asserted he had a close professional relationship with her which suggested she was not suicidal and he saw her husband as well. He stated he was clinically, deeply involved with Patient A. He did not apologise to her because she was entirely happy with his prescribing. He told the Tribunal that there would always be exceptional patients who could handle the use of benzodiazepines long-term and that he would not prescribe such drugs ‘willy nilly’.

10. He told the Tribunal that he had twice attempted to refer Patient A to a psychiatrist and suggested a referral on many other occasions, but Patient A had resisted because of the cost of £400 for a private psychiatric consultation. He did not accept that he lacked insight. He reminded the Tribunal that he had altered his
medical practice and adopted new methods such as using pro-formas to record consultations which, he said, was a major decision and reflected the degree of his review of his practice as well as that of his contrition.

11. In relation to his professional training, Dr Dighton told the Tribunal that he had trained in cardiology. On moving to private practice in 1982 he had undergone no formal GP training, but stated that it was unnecessary due to his work in general medicine and the minor nature of his patients’ ailments. In relation to his treatment of Patient A, she had initially presented seeking pain relief and treatment for vertigo. He told the Tribunal that he had no certificate in pain management but had worked at one time as an anaesthetist in the early stages of his career. He told the Tribunal that in his view in 2011 when he began treating Patient A he was working within the limits of his competence. His competency to treat an addictive person, he said, arose from his experience and judgement. When asked about working within his competency and areas of expertise, he maintained that he used 53 years’ of clinical experience to make judgements.

12. Dr Dighton, when asked if he posed a risk to patients in the future, asserted that he does not, because ‘having removed all contentious issues, it’s simply impossible’.

**GMC Submissions**

13. Ms Dudley-Jones reminded the Tribunal of its findings on the facts and at the impairment stage, which related to Dr Dighton’s poor performance, his risky prescribing, lack of focussed training, lack of insight, lack of remedial action and reflection into the matters which brought him before the Tribunal. She also reminded the Tribunal that Dr Dighton had been issued with advice by the GMC and issued with a warning, which was still in effect, relating to his practise of prescribing benzodiazepines outside the accepted guidelines. She submitted that Dr Dighton’s evidence before the Tribunal at the sanction stage demonstrated no real or meaningful insight on his behalf as to why he had continued with similar conduct after being issued with advice and a warning from his regulator. She submitted that Dr Dighton appeared not to accept that he had repeated his actions.

14. Ms Dudley-Jones submitted that Dr Dighton had demonstrated some reflection in that he accepted that he should have acted differently. However, she submitted that his lack of apology indicated that he did not consider that he had done anything wrong. She reminded the Tribunal that Dr Dighton is a very senior practitioner who, at one stage, had 20,000 private patients. In those circumstance, she submitted that he should be aware of his wrongdoing.

15. Ms Dudley-Jones stated that the Tribunal’s finding of misconduct cannot be said to be isolated given that there was a warning in place on Dr Dighton’s registration relating to similar concerns. He placed Patient A, a vulnerable patient
with addiction and mental health issues, at a serious risk of harm. She also submitted that his lack of insight means that his patients remain at risk of harm. Furthermore, she submitted, his actions undermine the confidence which the public is entitled to place in members of the medical profession.

16. Given the serious nature of this case and Dr Dighton’s failure to acknowledge fault, Ms Dudley-Jones submitted that the imposition of conditional registration was neither sufficient nor appropriate. She submitted that the appropriate sanction in this case is one of suspension. She reminded the Tribunal that it has the power to erase Dr Dighton from the medical register but that this was a matter for the Tribunal, taking account of its view of his insight and remediation.

Submissions on Dr Dighton’s behalf

17. Mr Brassington submitted that insight can be demonstrated through words or actions. He reminded the Tribunal that Dr Dighton had in December 2018 ceased to do the type of work which had led to his appearance before this Tribunal. He also submitted that it was to Dr Dighton’s credit that he had made a number of admissions at the outset of this hearing. In so doing, Dr Dighton had accepted that he had issued prescriptions to a patient when he did not have the relevant expertise and that he was not competent to treat a patient with complex medical needs.

18. On his behalf, Mr Brassington accepted that Dr Dighton had ignored the GMC’s advice and breached the warning imposed. He submitted, however, that it was not right to characterise such a breach as wilful. He submitted that Dr Dighton is a well-intentioned clinician who had sought to do the best for his patient. Mr Brassington stated that Dr Dighton had apologised and expressed regret for his failures. He reminded the Tribunal that Patient A had not lodged a complaint against Dr Dighton and, in those circumstances, there could be no criticism of his failure to apologise to her.

19. Mr Brassington informed the Tribunal that Dr Dighton had begun the process of ceasing to treat and prescribe patients with benzodiazepines before he had ceased to practise as a GP. He reminded the Tribunal that Dr Dighton had de-registered himself as a GP with the CQC and in those circumstances, Mr Brassington submitted that Dr Dighton poses no future risk to patients as he can no longer do that sort of work. He submitted that Dr Dighton’s actions in so doing show that he has reflected and demonstrated insight.

20. Mr Brassington submitted that the appropriate sanction in this case was one of conditions. He stated that Dr Dighton had already been taking steps such as working under supervision, restricting his practice and ceasing to prescribe and that the imposition of a set of conditions similar to those already in place on an interim basis would achieve the Tribunal’s statutory purpose. He submitted that such conditions would protect patients and the public interest. He further submitted that a
sanction of any greater severity imposed would be a punishment and as such would be unnecessary and disproportionate.

The Tribunal’s Determination on Sanction

21. The decision as to the appropriate sanction to impose, if any, in this case is a matter for this Tribunal exercising its own judgement.

22. In reaching its decision, the Tribunal has taken account of the Sanctions Guidance. It has borne in mind that the purpose of the sanctions is not to be punitive, but to protect patients and the wider public interest, although they may have a punitive effect.

23. The Tribunal gave careful consideration to the aggravating and mitigating factors present in Dr Dighton’s case.

Mitigating factors

24. The Tribunal gave credit to Dr Dighton for the admissions which he had made at the outset of this hearing. These admissions included that he had prescribed benzodiazepines to Patient A, that the prescriptions had been excessive, that he had failed to monitor the frequency of prescriptions issued and that he had not kept an adequate record relating to his consultation with Patient A on 10 October 2016. The Tribunal bore in mind that the admissions made by Dr Dighton were matters of fact set out within the evidence adduced in this case and would, in those circumstances, have been difficult to deny. Dr Dighton had not admitted facts relating to his failure to inform Patient A’s GP, assess her mental health or her risk of suicide and his failure to refer her to a psychiatrist. These matters were determined and found proved by the Tribunal and, in the Tribunal’s view, represented the true gravity of the case.

25. The Tribunal accepted Dr Dighton’s assertion that for 53 years he had received no complaints from any patients and that there had been no patient complaints before a Medical Practitioners Tribunal to date.

26. The Tribunal in its determination on impairment dated 14 March 2019 noted the risk of repetition due to Dr Dighton’s minimal insight, his unfocused training, a lack of apology and no reflective practice. Thereafter, Dr Dighton set out an apology to the Council at paragraph 17 of his statement dated 29 March 2019, in which he stated:

“I recognise that I made errors on judgment [sic] in relation to Patient A and that I did not have the experience that a doctor dealing with addictions would have had and which might have enabled him to appreciate what was happening. I also acknowledge that I did not make adequate notes and that
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contributed to my failure to appreciate the true position. I apologise to the
Council for my errors.”

27. The Tribunal noted that this was the only apology which Dr Dighton made
and that he had made it after the Tribunal’s findings on facts and impairment.

28. Although no testimonial evidence had been adduced on Dr Dighton’s behalf,
the Tribunal took account of a note produced by Patient A at his behest, dated 19
January 2018, related to his treatment of her in which she stated:

“I have absolutely no complaints about Dr Deighton [sic], his care for me has
been faultless he has time & understanding for me I have a treatment plan
for me which he follows stringently he makes me feel safe at all times, if I
had any complaints I would choose not to use him as my Doctor like I chose
not to be treated by a GP...”

29. The Tribunal noted that, whilst Patient A was complimentary about Dr
Dighton, she was a drug addict throughout this period when Dr Dighton was
supplying her with prescription medication.

Aggravating factors

30. The Tribunal took account of Sanctions Guidance (paragraphs 51 and 52) in
relation to its consideration of Dr Dighton’s insight. Those paragraphs state:

“51 It is important for tribunals to consider insight, or lack of, when
determining sanctions. It is particularly important in cases where the doctor
and the GMC agree undertakings or the tribunal imposes conditions. The
tribunal must be assured that this approach adequately protects patients, in
that the doctor has recognised the steps they need to take to limit their
practice to remediate.

52 A doctor is likely to lack insight if they:

a refuse to apologise or accept their mistakes

b promise to remediate, but fail to take appropriate steps, or only do so when
prompted immediately before or during the hearing

c do not demonstrate the timely development of insight

d fail to tell the truth during the hearing”

31. The Tribunal bore in mind Mr Brassington’s submission that Dr Dighton’s
decision to desist from GP work and prescribing demonstrated his insight. The
Tribunal took account of the fact that Dr Dighton’s decision so to do had been pre-empted by regulatory pressure. NHS England had raised concerns relating to Dr Dighton’s prescribing and work as a GP in June 2017. The GMC imposed a warning on 22 July 2016. It took the view that Dr Dighton’s decision to cease that type of work was simply doing what he should have done in any event, that is to work within the limits of his competency.

32. The Tribunal determined that Dr Dighton’s evidence before it at the sanction stage reinforced its earlier impairment finding that he lacks insight. He indicated that his own knowledge and experience was superior to the accepted guidance of the BNF, National Institute of Clinical Excellence (NICE) and NHS England and that he was able, through his experience and clinical judgement, to recognise what he termed ‘exceptional’ patients who could handle long-term use of benzodiazepines. The Tribunal characterised Dr Dighton’s lack of insight as intractable.

33. The Tribunal also found that features of Dr Dighton’s treatment of Patient A amounted to aggravating factors. He had, over a sustained period of time, prescribed benzodiazepines to Patient A in excessive quantities. He had failed to inform her GP of those prescriptions, failed to make adequate records and failed to adequately assess Patient A and appropriately refer her for psychiatric treatment.

34. The Tribunal concluded that, as a result of her mental health and addiction issues, Patient A was a vulnerable patient who was at risk of an accidental or deliberate overdose. Dr Dighton was clearly aware of this vulnerability as he had written to the pharmacist on 11 July 2012:

“I entirely agree that it would be best if they [Patient A] came to one pharmacy only for their supplies of their sedative drugs. I was aware right from the start that they were a potential problem, claiming that they had lost tablets, that they had left them in Spain, and that the other partner had taken more of them than prescribed. As we agreed over the telephone, this is clearly the behaviour of addicts and therefore any way that we can restrict them and create an obligatory rule, the better.”

35. The Tribunal took the view that, in his evidence before it, Dr Dighton had blamed Patient A, stating that she had been ‘clever and manipulative’. It concluded that he should, in fact, have recognised Patient A’s behaviour as being symptomatic of addiction. It also took the view that this evidence further demonstrated Dr Dighton’s lack of expertise.

36. The Tribunal concluded that the case relating to Patient A was not isolated. By Dr Dighton’s own admission he had been prescribing benzodiazepines on a long-term basis to 20 other patients.

**No action**
37. In coming to its decision as to the appropriate sanction, if any, to impose in Dr Dighton’s case, the Tribunal first considered whether to conclude the case by taking no action. The Tribunal concluded that no action was not proportionate as it would not protect patients, maintain confidence in the profession or professional standards.

Conditions

38. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Dighton’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 the actions taken by Dr Dighton in restricting his own practise. It also noted that he had been working under supervision and had complied with interim conditions imposed on his registration.

40. Nonetheless, the evidence before the Tribunal demonstrates that Dr Dighton had been working beyond the limits of his competency for a sustained period of time. His conduct relating to Patient A was serious and his treatment of her put her at risk of harm. Dr Dighton does not accept that in 2011 he was not competent to treat her, even in the light of his recognition that she was a drug addict as set out in his letter to a pharmacist in 2012. He continued treating her until 2017.

41. Dr Dighton was resistant to the regulatory and control norms and lacked relevant training. He was unable in the course of his evidence to shift his position. He failed to act in response to the warning issued by the GMC. His evidence had a sense that he knew better than the regulators because reliance on his own clinical judgement was a sufficient safeguard. He still does not accept that Patient A was at risk of even an accidental overdose from the excessive quantities of prescription drugs which he prescribed.

42. The Tribunal concluded that the imposition of conditions might have been sufficient to protect the wellbeing of the public. However, it concluded that the imposition of conditions is not a sufficient sanction to reflect the serious nature of Dr Dighton’s misconduct. It considered Dr Dighton’s misconduct to have been deliberate and that he had demonstrated little insight.

43. In the circumstances, it concluded that conditions were not sufficient to protect public confidence in the medical profession nor to promote and maintain proper professional standards and conduct of the profession.

Suspension
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44. The Tribunal then went on to consider whether suspending Dr Dighton’s registration would be appropriate and proportionate.

45. The Tribunal concluded that Dr Dighton did not have the competence to treat Patient A and manage her condition. It considered that he had placed Patient A at a serious risk of overdose over a protracted period of time. The evidence he gave to the Tribunal at the sanction stage indicated that, fundamentally, he still believed that there was no wrongdoing on his part.

46. The Tribunal also concluded that Dr Dighton had flouted the efforts of his regulator to bring his practise into line with accepted professional standards and guidelines. His evidence before the Tribunal at the sanction stage demonstrated that he still believed that he knew better. He had ignored the warning imposed on his registration by the GMC in 2016 relating to almost identical behaviour, which was in effect during the course of his treatment of Patient A and, indeed, remains in force until 2021.

47. The Tribunal took account of paragraph 109b of Sanctions Guidance which indicates factors which may indicate that erasure is the appropriate sanction:

“A deliberate or reckless disregard for the principles set out in Good Medical Practice and/or patient safety”

48. The Tribunal took the view that Dr Dighton’s conduct in relation to Patient A had demonstrated a blatant disregard for safeguards and jeopardised her well-being. His treatment of Patient A demonstrated the limits of his knowledge and the fact that he was working beyond his competence. His conduct undermines the trust which the public is entitled to place in the medical profession.

49. Nonetheless, the Tribunal took account of the actions taken by Dr Dighton to restrict his practise and it has, therefore, determined that his conduct is not fundamentally incompatible with his inclusion on the medical register.

50. The Tribunal took account of Sanctions Guidance at paragraph 97 which indicates the factors which indicate that suspension might be appropriate:

“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.

...
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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.”

51. The Tribunal is concerned about Dr Dighton’s level of insight and did consider whether, in the circumstances, erasure was a more appropriate sanction. However, in the light of Dr Dighton having desisted from offering GP services and his compliance with interim conditions in relation to his cardiology work, the Tribunal consider his misconduct is not fundamentally incompatible with his continued registration.

52. The Tribunal considered paragraph 91 of Sanctions Guidance which states:

“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.”

53. The Tribunal determined that nothing less than a suspension would satisfy all three limbs of the overarching objective in this case. This is a highly restrictive measure and the it took the view that such a sanction adequately reflected the serious failings on Dr Dighton’s part.

54. The Tribunal determined to suspend Dr Dighton for a period of 12 months.

55. In determining the length of the suspension, the Tribunal took account of the serious nature of the findings in this case and the gravity of the aggravating factors, in particular Dr Dighton’s lack of insight.

Review hearing directed

56. The Tribunal determined to direct a review of Dr Dighton’s case. A review hearing will convene shortly before the end of the period of suspension unless an earlier review is sought. The Tribunal wishes to clarify that at the review hearing the onus will be on Dr Dighton to demonstrate how he has developed insight. It might, therefore, assist the reviewing Tribunal if Dr Dighton:
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- Demonstrates insight into how his treatment of Patient A jeopardised her wellbeing, and placed her at risk of an overdose;
- Demonstrates insight into how he had been working above the limits of his competence; and
- Evidence of how he has kept his medical knowledge up to date during the period of his suspension.

57. Dr Dighton will also be able to provide any other information that he considers will assist.

Determination on Immediate Order - 29/10/2019

1. Having determined to suspend Dr Dighton’s registration for 12 months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Dighton’s registration should be subject to an immediate order.

GMC Submissions

2. Ms Dudley-Jones submitted that an immediate order was necessary. She submitted that in this case an order is necessary to protect the public. She stated that Dr Dighton poses a risk to patient safety and reminded the Tribunal that it had found, at its sanction stage, that he had shown a blatant disregard for safeguards and had jeopardised Patient A’s safety. She also reminded the Tribunal that if no immediate order is imposed Dr Dighton will be free to practise without restrictions during the appeal period or, in the event of an appeal, until that appeal had been determined. In the circumstances, Ms Dudley-Jones submitted that the Tribunal should make an interim order to protect patient safety.

Submissions on Dr Dighton’s behalf

3. Mr Brassington made no submission in relation to the imposition of an interim order.

The Tribunal’s Determination

4. In making its decision the Tribunal exercised its own judgement. Dr Dighton was not present at today’s hearing. Mr Brassington, his representative, made no application for an adjournment on his behalf.
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5. It bore in mind its serious findings relating to his treatment of Patient A; findings which were not isolated in Dr Dighton’s medical practice. He had placed a vulnerable patient at risk of serious harm. He had also failed to work within the limits of his competence. Dr Dighton’s insight remains very limited in regard to his misconduct. Currently he is working under conditions imposed by an Interim Order which includes supervision of his work in cardiology. This Tribunal has found Dr Dighton to be unwilling to accept the seriousness of his misconduct and has little confidence that he would not again rely upon his experience and clinical judgement rather than seek the opinion of his supervisor. This Tribunal found his conduct to be unbefitting of a member of the medical profession.

6. The Tribunal has considered whether the imposition of an Immediate Order is necessary and/or whether this is in the wider public interest. It is both necessary and in the wider public interest.

7. In all the circumstances, the Tribunal determined to impose an immediate order of suspension on Dr Dighton’s registration. This means that Dr Dighton’s registration will be suspended from today. The substantive direction, as already announced, will take effect 28 days from today, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

8. The interim order currently imposed on Dr Dighton’s registration will be revoked when the immediate order takes effect.

9. That concludes this case.

Confirmed
Date 29 October 2019

Miss Gillian Temple-Bone, Chair
Application to amend the Allegation

1. Ms Dudley-Jones made an application for the amendment of the Allegation as follows:

   (A) paragraph 6(b)(i) and Schedule 2;
   (B) paragraph 6(e)(ii);
   (C) the addition of paragraph 8 and Schedule 6 to the Allegation, namely the warning received by Dr Dighton in 2016.

2. The proposed amendments would be:

   Paragraph 6(b)(i):
   “b. the prescriptions as referred to at paragraph 6(a) above were excessive in that:

   i. the interval between one or more of those prescriptions was too short in order for Patient A to be taking co-proxamol according to the prescribed dose of one tablet four times daily and/or one tablet three times daily;”

   Paragraph 6(e)(ii):
   “e. you issued the prescriptions set out in Schedules 1 to 5 without:

   ii. appropriately referring Patient A to mental health services;”

   Paragraph 8:
   “8. Between 22 July 2016 and 10 October 2017 your actions set out in paragraphs 2 to 7 were undertaken when you were the subject of an active GMC warning in respect of similar conduct as outlined in Schedule 6.”

   Schedule 2:
   “9 February 2017 200 x 1 tds QDS”

   Schedule 6:
   “GMC Warning imposed on 22 July 2016

   “Dr Dighton prescribed benzodiazepine based drugs to two of his patients on a long term basis. He did not refer the patients to secondary psychiatric services. He failed to devise a treatment plan for the prescribing of the medication. He did not inform
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the patients’ NHS GPs of his prescribing regime. On many occasions prescriptions were issued without seeing the patients face to face.

This conduct does not meet with the standards required of a doctor. It risks bringing the profession into disrepute and it must not be repeated. The required standards are set out in Good Medical Practice and associated guidance. In this case, paragraphs 11, 15(c) and 16(a) of Good Medical Practice are particularly relevant:

‘You must be familiar with guidelines and developments that affect your work’

‘You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

(c) refer a patient to another practitioner when this serves the patient’s needs’

‘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’.

Whilst these failings in themselves are not so serious as to require any restriction on Dr Dighton’s registration, it is necessary in response to issue this formal warning.

This warning will be published on the List of Registered Medical Practitioners (LRMP) for a period of five years and will be disclosed to any person enquiring about Dr Dighton’s fitness to practise history. After five years, the warning will cease to be published on LRMP however it will be kept on record and disclosed to employers on request.”

GMC Submissions

(A) paragraph 6(b)(i) and Schedule 2

3. Ms Dudley-Jones stated that the GMC expert, Dr D, had double checked the prescriptions set out in Schedule 2 and had identified that one prescription for co-proxamol on 9 February 2017 was in fact one tablet three times a day (‘tds’) rather than one tablet four times a day (‘QDS’) as currently drafted. Ms Dudley-Jones stated that this amendment did not affect Dr D’s opinion and did not alter the case that Dr Dighton has to meet. She proposed to add the words “and/or one tablet three times daily” to paragraph 6(b)(i) of the Allegation to reflect this minor change.

(B) paragraph 6(e)(ii)
Ms Dudley-Jones stated that this amendment was identified in conference with Dr D on 17 January 2019. She stated that she had been unable to attend the originally scheduled conference on 8 January 2019 due to health reasons. Had this taken place, the amendment would have occurred prior to the notice of allegation being issued on 14 January 2019. Ms Dudley-Jones submitted that the word “appropriately” should be added to paragraph 6(e)(ii) of the Allegation and that this would reflect the expert evidence of Dr D, at page 37 of her report. She submitted that this was not new evidence as it was in accordance with Dr D’s opinion and report so did not alter the case against Dr Dighton.

(C) the addition of paragraph 8 and Schedule 6 to the Allegation, namely the warning received by Dr Dighton in 2016

Ms Dudley-Jones stated that Dr Dighton is subject to a warning which was imposed on 22 July 2016 for a period of five years. It was imposed by the GMC Investigation Committee at a hearing. Ms Dudley-Jones submitted that the warning was relevant because between 22 July 2016 and 10 October 2017 (the last date alleged in the Allegation), it is alleged that Dr Dighton’s actions in paragraphs 2 to 7 of the Allegation were undertaken whilst he was subject to an active GMC warning in respect of similar conduct.

Ms Dudley-Jones submitted that this warning was a matter of public record. She stated that this was a simple factual allegation, was not a separate misconduct allegation and has always been part of the GMC’s case against Dr Dighton. Ms Dudley-Jones submitted that the warning was disclosed as part of the GMC’s investigation.

Ms Dudley-Jones submitted that the warning was highly relevant. Dr Dighton prescribed benzodiazepine based drugs to two of his patients on a long term basis. He did not refer the patients to secondary psychiatric services. He failed to devise a treatment plan for the prescribing of the medication. He did not inform the patients’ NHS GPs of his prescribing regime. On many occasions prescriptions were issued without seeing the patients face to face. She asked the Tribunal to amend the Allegation, to add paragraph 8 and Schedule 6, to reflect the factual position regarding the warning.

Ms Dudley-Jones submitted that the GMC was not alleging that a breach of the warning had taken place. She stated that Dr Dighton, at the time of the alleged events, was subject to a warning. Ms Dudley-Jones submitted that the warning was plainly relevant and admissible.

Ms Dudley-Jones submitted that the Tribunal does not need to see the underlying material that was before the GMC Investigation Committee. She suggested that the Tribunal may choose to see the determination of the Investigation Committee but even without that the only thing required by the
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Tribunal is the warning itself. She stated that the warning issued by the Investigation Committee was the end of those matters and the GMC cannot bring separate charges in relation to them.

10. With regards to propensity, Ms Dudley-Jones submitted that the issue of a warning is not evidence of propensity but the content of the warning is. She suggested that a doctor might well have been warned on another irrelevant matter but, when it is almost identical behaviour, then there is evidence of propensity to act a certain way. Ms Dudley-Jones stated that she did not accept that proper analysis of propensity would have to follow a consideration of the underlying material that had been before the Investigation Committee.

Submissions on Dr Dighton’s behalf

(A) paragraph 6(b)(i) and Schedule 2
(B) paragraph 6(e)(ii)

11. Mr Brassington submitted that there was no objection taken to these two proposed amendments to the Allegation.

(C) the addition of paragraph 8 and Schedule 6 to the Allegation, namely the warning received by Dr Dighton in 2016

12. Mr Brassington submitted that objection was taken to this proposed amendment. He stated that the relevant test to be applied was whether the amendment can be made without injustice and if such an amendment was fair in all the circumstances. Mr Brassington submitted that the amendment could not be made without injustice. He stated that it was a narrow but extremely serious issue and that the question of fairness must be the test that the Tribunal applies.

13. Mr Brassington submitted that this amendment was too late to permit a fair hearing. Whilst the warning had been referred to in information disclosed to Dr Dighton, Mr Brassington stated that it has never formed part of any particulars of the Allegation. He stated that it was the GMC’s responsibility to determine the particulars of the Allegation. The GMC seeks to amend the Allegation on the morning of the first day of this hearing, albeit on two weeks’ notice, and it is an application to completely amend the tone and substance of the case that Dr Dighton faces. He submitted that if the warning was central to the GMC’s case then it should have particularised this in the Allegation. To now seek to make it part of its case, at this stage, is unfair.

14. Mr Brassington referred to the GMC suggestion that a warning is a matter of public record. He stated that this was irrelevant as the starting point for the inclusion of any additional material. That the material might be freely available to the public is of no consequence.
15. Mr Brassington referred to the GMC suggestion that it was not alleging that there had been a breach of the warning. He referred to Ms Dudley-Jones’ submissions and stated that they suggest that it is alleged that there was a failure by Dr Dighton to comply with the warning. Mr Brassington submitted that, if there is no breach, it cannot be relevant to the Tribunal but if the GMC case is that there has been a breach then this is the first time that Dr Dighton has been made aware of this, on the first day of this case, and that is not fair.

16. With reference to the wording of the proposed paragraph 8 of the Allegation, namely that the warning was in respect of similar conduct, Mr Brassington submitted that this was not self-evident. He stated that the Tribunal cannot read the warning and have an understanding of the two cases referred to. Mr Brassington stated that a proper and fair analysis of the similarity or otherwise of the conduct would have to follow consideration of the underlying material that was before the GMC Investigation Committee. Mr Brassington stated that the GMC has not provided this underlying material to this Tribunal. He submitted that the Tribunal is therefore not able to say that the cases are strikingly similar.

17. Mr Brassington addressed the GMC suggestion that the issuing of a warning was evidence of propensity by Dr Dighton. He took the Tribunal through the process that is following in relation to the GMC Investigation Committee, including that it does not litigate any factual dispute or hear evidence, it is an exercise that is undertaken on the papers. Mr Brassington submitted that, absent the underlying material, the Tribunal is deprived of the chance to see if there is any propensity. As to the question of whether there has been similar conduct, he submitted that a proper analysis of propensity could only follow the consideration of the underlying material which was before the GMC Investigation Committee.

18. Mr Brassington submitted that having sight of the warning does not assist the Tribunal to decide the facts as alleged in relation to Patient A. He stated that this was something that the GMC must establish and that the warning would not assist the Tribunal with this. Mr Brassington acknowledged that the GMC might have a better argument as to the relevance of the warning at the impairment stage, should this be reached, but submitted that it was completely irrelevant to the facts stage of this hearing.

19. In conclusion, Mr Brassington submitted that it would be unfair to permit the proposed amendment. He submitted that it would introduce irrelevant and prejudicial material and deprive Dr Dighton of a fair hearing. Mr Brassington stated that it also comes too late and without proper notice to allow Dr Dighton to properly rebut any suggestion of propensity, lack of insight or defence against the suggestion that the conduct was strikingly similar.

Tribunal’s Decision
20. The Tribunal had regard to Rule 17(6) of the Rules, as follows:

"Where, at any time, it appears to the Medical Practitioners Tribunal that-
(a) the allegation or the facts upon which it is based and of which the
practitioner has been notified under rule 15, should be amended; and
(b) the amendment can be made without injustice,
it may, after hearing the parties, amend the allegation in appropriate terms."

(A) paragraph 6(b)(i) and Schedule 2
(B) paragraph 6(e)(ii)

21. The Tribunal determined to grant the GMC's application to amend the
Allegation in respect of (A) and (B). It noted the agreement of the parties and the
explanation for the need for the amendment as detailed by the GMC. The Tribunal
accepted that reasoning and considered that both amendments did not significantly
alter the case that Dr Dighton has to face. It determined that the amendments could
be made without any injustice.

(C) the addition of paragraph 8 and Schedule 6 to the Allegation, namely the
warning received by Dr Dighton in 2016

22. The Tribunal determined to refuse the GMC's application to amend the
Allegation as at (C), in relation to the inclusion of reference to the warning. It
concluded that the amendment could not be made without injustice to Dr Dighton.

23. The Tribunal had regard to the submissions in respect of propensity and
similarity in Dr Dighton’s conduct. It noted that it does not have the underlying
material provided to the GMC Investigation Committee. It determined that the
warning, on its own, does not inform the Tribunal about propensity, even if the
matters could appear to be similar in nature to the allegations currently before this
Tribunal. The Tribunal determined that the GMC's case has been brought in reliance
upon evidence regarding Dr Dighton’s consultations, treatment and prescribing
history regarding Patient A.

24. The Tribunal noted that the warning was public information but was of the
view that it would be prejudicial to Dr Dighton if the GMC was permitted to now
amend its case to allege that he had breached the warning and that there was a
repetition of past conduct. The Tribunal was mindful that the allegations should
stand or fall on their own factual circumstances, namely if there is evidence that
Dr Dighton acted in the ways alleged. It acknowledged, as referred to in
Mr Brassington’s submissions, that the matter of a warning may be of relevance at
the impairment or sanction stages of a hearing, should these be reached, but not to
the facts stage. The Tribunal determined that it should only consider what is
relevant to the facts alleged in order for it to properly and fairly adjudicate on this matter.

25. The Tribunal had regard to Dr Dighton’s own interests and the public interest in this case. It concluded that the public interest is not harmed by the refusal to amend the Allegation in relation to the warning. This is because the public interest has been served by the bringing of these proceedings which will be determined on the basis of the facts currently alleged against Dr Dighton. The Tribunal was of the view that, if it was the GMC’s case that it was alleging a breach of the warning, then this should have been included in the Allegation at an earlier stage. The time to add this to any Allegation was not on the first day of a hearing. The case should stand or fall on the facts as set out at paragraphs 1 to 7 of the Allegation.

ANNEX B - 26/02/2019

Application to admit further evidence

1. Ms Dudley-Jones made an application under Rule 34(1) of the Rules to admit further evidence:

- The wording of a warning issued to Dr Dighton in July 2016 as contained after paragraph 25 in the determination of the GMC Investigation Committee;
- A document (Exhibit C2) dated 28 July 2016 entitled “To all patients taking sleeping tablets”, which is a notice signed by Dr Dighton addressed as set out above to patients including Patient A;
- All references to the warning within the documents contained in Exhibit C1, including pages 360 and 437.

GMC Submissions

2. Ms Dudley-Jones submitted that this application was made, mindful of Annex A, for the admission of the above information. She stated that Dr Dighton was subject to the warning in 2016 and this was referred to in the written document disclosed to Dr Dighton in this case. Ms Dudley-Jones stated that the GMC proposes to heavily redact the determination of the Investigation Committee so that it will only contain the wording of the warning as set out in Schedule 6 of Annex A that was placed before the Tribunal on 25 February 2019.

3. Ms Dudley-Jones stated that yesterday, 25 February 2019, for the first time Mr Brassington confirmed that Dr Dighton will not provide a written statement, give oral evidence or call any other witnesses. She submitted that this was the first time that this had been unequivocally confirmed to the GMC. Ms Dudley-Jones submitted that it then became clear that there would be no further evidence submitted.
4. In relation to paragraph 2(b) of the Allegation, Ms Dudley-Jones stated that it only became clear from Mr Brassington’s skeleton argument that Dr Dighton would contend that he did not have the necessary consent from Patient A to disclose the medications to her General Practitioner (GP). She referred to Exhibit C2 and that this involved Dr Dighton writing to Patient A to inform her that he had to write to her GP to inform them of the prescriptions he had issued. Ms Dudley-Jones submitted that there was no suggestion that Patient A had not given consent in this regard to Dr Dighton. Ms Dudley-Jones submitted that the admission of this document and the reference to the warning is important to assist the Tribunal to determine a number of sub-paragraphs of the Allegation, namely paragraph 2(b), 3(e) and 6(e).

5. With reference to paragraph 6(e)(ii) of the Allegation, Ms Dudley-Jones stated that Exhibit C2 will assist the Tribunal. She stated that Dr Dighton had received the warning in 2016 and then NHS England investigators wrote to him on 16 June 2017 concerning his prescribing. Ms Dudley-Jones submitted that Dr Dighton then referred Patient A to a psychiatrist, Dr H, for the first time on 23 June 2017. The GMC contends that this referral only took place as a consequence of the pressure of the NHS England investigation. The fact of the warning was important to allow the Tribunal to determine the Allegation in this respect.

6. Ms Dudley-Jones submitted that if the warning was excluded it would deprive the Tribunal of material evidence of what was happening at the time in question and leave the Tribunal in a position where it is not able to determine Dr Dighton’s actions. She submitted that it was entirely fair to admit the evidence of the warning and for the Tribunal to consider this when determining what Dr Dighton did or did not do in relation to Patient A.

7. In response to Mr Brassington’s submissions, Ms Dudley-Jones submitted that the GMC was not in any panic or attempting to put a ‘sticking plaster’ on the case. She stated that the Tribunal should not be hoodwinked, that it has the medical records for Patient A and that consent will ultimately be a matter for the Tribunal to determine on those documents before it. Ms Dudley-Jones submitted that she made the application to help the Tribunal know the context at the time in question.

Submissions on Dr Dighton’s behalf

8. Mr Brassington submitted that this application represents a refusal by the GMC to accept the Tribunal’s decision at Annex A. He reminded the Tribunal that the burden of proof rests with the GMC in proving the Allegation against Dr Dighton. Mr Brassington submitted that the GMC had failed in its duty to prepare this case, to particularise the Allegation and properly analyse the evidence it had available. He suggested that the GMC is now attempting, in an unfair fashion, to cover up that failing by its application at Annex A and then, when this did not succeed, to make another application and put the same information before the Tribunal.
9. Mr Brassington stated that Dr Dighton intends to make a number of admissions to the Allegation if the hearing begins. He indicated the admissions that Dr Dighton would make, namely line 1 of paragraph 1, paragraphs 2(a), 3(d), 5(a), 5(b)(i) and (ii), 6(a)(v), 6(b)(i), 6(c), 6(d), 6(e)(iv) and 7 in its entirety, “which properly reflects the gravamen of this case”. He submitted that what will remain will be a series of allegations that cannot be proved given the evidential deficit in the GMC’s case due to the absence of evidence from Patient A. Mr Brassington stated that it had only just become apparent to the GMC that it does not have the evidence to prove the remaining charges in the Allegation.

10. Mr Brassington submitted that, if the GMC wishes to establish that Dr Dighton failed to tell Patient A’s GP of the prescribed medication, the GMC has first to establish that there was consent given by Patient A for the sharing of this information. He stated that this application was an attempt to act as a ‘sticking plaster’ to try to resolve this point.

11. With reference to the relevance of the warning, Mr Brassington contended that the suggested ‘heat’ was from the NHS England investigation letter dated 16 June 2017 and had nothing to do with the warning, which was imposed 18 months previously. Mr Brassington submitted that it was a smoke screen to try to persuade the Tribunal that the evidence was now relevant. He submitted that there was no allegation in this case as to the motive behind Dr Dighton’s referral of Patient A to a psychiatrist.

12. Mr Brassington submitted that the application should be refused. He submitted that the warning was of no relevance to the Allegation in this case and the admission of the documents was not something that should be contemplated by the Tribunal.

Additional Query from the Tribunal

13. The Tribunal reconvened to request documents the GMC expert, Dr D, had sight of and relied upon in her report, and a document that Ms Dudley-Jones referred to in her submissions:

- A letter dated 16 June 2017 from NHS England to Dr Dighton, which advised him of concerns it had regarding his prescribing, as referred to in Ms Dudley-Jones’ submissions;
- Dr Dighton’s submissions (redacted) and Curriculum Vitae;
- Dr Dighton’s statement as referred to at a number of points within the report, unless this is in reference to the submissions as detailed above;
- A tabulated record of private prescriptions issued from 5 January 2017 to 10 October 2017.
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14. The Tribunal accepted submissions by both parties that it would be preferable to resolve the current application before the matter of these documents is considered.

Tribunal’s Decision

15. The Tribunal noted that the admission of further evidence is a matter for the Tribunal to assess with regard to the questions of fairness and relevance. It had regard to Rule 34(1) of the Rules:

"The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law."

16. In relation to the warning, the Tribunal determined to refuse the GMC’s application in this regard. It was of the view that the fact and wording of the warning is not evidence in itself as it is a regulatory instrument arising from Dr Dighton’s failure in his duty. The Tribunal noted that a doctor’s duty arises from the principles set out in Good Medical Practice (GMP). Therefore any failure by Dr Dighton to adhere to those principles as alleged in the Allegation will arise from him not adhering to the standards of GMP.

17. The Tribunal determined that the warning does not impose a higher duty for Dr Dighton’s practice than the principles set out in GMP.

18. The Tribunal considered the test as set out in Rule 34(1) above, that it may admit any evidence that it considers to be fair and relevant. The Tribunal did not consider that the admission of the warning, and its content, to be relevant to its consideration at the facts stage of this hearing. The Tribunal noted that the warning may well become relevant should a further stage be reached, as acknowledged in the earlier application by Mr Brassington on behalf of Dr Dighton.

19. As such, the Tribunal was mindful that a number of references to the warning in Exhibit C1 will not be admitted as a result of its decision, including references at pages 360 and 437.

20. In relation to Exhibit C2, the Tribunal determined to grant Ms Dudley-Jones’ application, albeit with reference to the warning removed. It determined that the document was relevant to the Tribunal’s consideration at the facts stage. It is a document created by Dr Dighton and provided by him in these proceedings. Therefore it would be fair to both parties to admit it. The Tribunal noted that the document was referred to in the chronology prepared by Dr D and related to the question of referral of Patient A to a psychiatrist. The Tribunal would determine the weight to place on the document later during its deliberations at the facts stage.
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Suggested redactions of Exhibits C1 and C2:

21. The Tribunal suggested the following redactions to Exhibits C1 and C2:

- Exhibit C1
  Page 360 - the removal of the words: "but I have a GMC warning on my registration concerning” and “that” from the first paragraph.

- Page 437 - the removal of the words: "because although he has 'no personal problem with controlling her usage’ he has a GMC warning which requires him to refer to psychiatry services” from the seventh paragraph.

- Exhibit C2
  The removal of the words from the first paragraph: "My prescribing of the above drugs to two patients has recently been reviewed by the GMC. They have warned me that” and “that”. The removal of the word "warning” from the second paragraph.

22. The Tribunal was of the view that it has made its position crystal clear with regard to the relevance of the warning at the facts stage of this hearing. It considered that it may be that the parties do not feel the need to further redact documents in that regard at this stage but that it is a matter for them.

ANNEX C - 28/02/2019

Application for Recusal

1. On 27 February 2019, Mr Brassington made an application that this Tribunal should recuse itself.

Submissions on Dr Dighton's behalf

2. Mr Brassington submitted that the starting point was the test set out within the case of Porter v Magill [2001] UKHL 67, that first it is necessarily to ascertain all the circumstances to suggest the court may be biased:

   "The question is whether the fair-minded and informed observer, having considered the facts, would conclude that there was a real possibility that the tribunal was biased.”

3. Mr Brassington stated that there have now been two applications made by the GMC, one for the amendment of the Allegation and one for the admission of material, which have not been granted. Both applications required the Tribunal to be made aware of material which it then excluded. He submitted that the GMC has thereby created a possibility of bias.
4. Mr Brassington stated that the Tribunal has concluded that the proposed amendment to the Allegation, to include the GMC warning, was not relevant. He submitted that the GMC has told the Tribunal that the fact of the warning and the conduct it complains of is highly relevant to what is to be litigated in this case. Mr Brassington stated that the GMC has said that the warning related to the prescription of benzodiazepine drugs on a long term basis: without informing the GP; without a referral to a psychiatrist; and issued without face to face consultation. He stated that the GMC, in its submissions, went on to argue that the warning was relevant to Dr Dighton’s propensity to act in the way alleged, classifying it as almost identical behaviour. Mr Brassington submitted that a breach of the warning was not the GMC’s case in its written submissions but that this argument was made in Ms Dudley-Jones’ oral submissions, i.e. that Dr Dighton was warned and then went on to do exactly what he was warned not to do. Mr Brassington submitted that this irrelevant and prejudicial material goes to the heart of what the Tribunal has to consider. He submitted that, now the Tribunal has determined the warning to be irrelevant and prejudicial, a fair-minded and reasonable observer would consider the possibility of bias in this case.

5. Mr Brassington stated that he knew the GMC would say that this is a professional tribunal who are well able to put matters out of its minds. He submitted that this argument did not have merit in this case as the material goes to the heart of the case. Mr Brassington submitted that the material was not referred to by accident and that the GMC has described it as highly relevant. He submitted that it was not a matter that could be swept aside; it was not a peripheral issue of little importance. In all the circumstances, it was proper for recusal to take place.

6. In response to Ms Dudley-Jones’ submissions, Mr Brassington submitted that the fact that the Tribunal has not indicated previously that the material has prejudiced it, or that it considered there was any unfairness, was not the test. He reiterated that the test was what a fair-minded and reasonable observer would think, not what this Tribunal thinks.

7. Further, Mr Brassington submitted that the remaining issues in this case related exactly to the issues as set out in the warning. He stated that Dr Dighton intends to admit the fact of a prescription being issued by him, that the intervals and dosages might have been excessive and that he lacked the expertise to do so. Mr Brassington submitted that the remaining issues related exactly to the warning, namely whether there was a referral of Patient A to a psychiatrist, whether the necessary history was taken to allow him to make judgements, and whether there was correspondence with the GP.

8. Whilst the Tribunal members are professional, only one of them is a lawyer. The test is to be applied to the judiciary in court and, whilst professionally trained, the Tribunal are not High Court Judges.
GMC Submissions

9. Ms Dudley-Jones submitted that the Tribunal has determined not to amend the Allegation and that to do so would be prejudicial. However, at no stage has the Tribunal said that hearing about the warning would prejudice the Tribunal. She stated that the Tribunal has not seen the underlying material leading to the warning and knows very little of Dr Dighton’s conduct, namely only the wording of the GMC warning.

10. Ms Dudley-Jones referred to Mr Brassington’s submissions in relation to the previous application that having sight of the warning does not allow the Tribunal to determine the facts and that it is irrelevant at the facts stage. Ms Dudley-Jones submitted that the Tribunal has determined not to accede to the GMC’s application to admit the warning and referred to the Tribunal’s reasoning that the fact of the wording of the warning is not evidence in itself. She stated that the Tribunal has identified that a doctor’s duty arises from GMP so that any failings in relation to any outstanding paragraphs of the Allegation arise from this and not the warning; the warning does not impose a higher duty on Dr Dighton’s practice than the principles of GMP.

11. Ms Dudley-Jones referred to the Tribunal’s decision in relation to the admission of further evidence in that the admission of the warning was not relevant at the facts stage of the hearing. She submitted that the Tribunal had not determined that it would be unfair to admit it or said that it would prejudice it. Ms Dudley-Jones submitted that it was not unfair or prejudicial that the Tribunal has heard of the warning. She stated that Mr Brassington had said that some admissions were to be made that went to the gravamen of the case and stated that these would be made by the time the Tribunal was to make a decision on the facts.

12. Ms Dudley-Jones submitted that the Tribunal is experienced and well able to hear evidence and matters that might be irrelevant and be able to put them out of its mind if it needs to. She stated that the Tribunal has determined that the warning was a regulatory instrument and, as professional people, the Tribunal can put the warning out of its mind to determine the outstanding paragraphs of the Allegation. Ms Dudley-Jones submitted that the outstanding matters could be considered on the evidence before the Tribunal. She stated that the Tribunal has no evidence from Patient A to determine what was said in the consultation and the outstanding allegations as to whether Dr Dighton informed Patient A’s GP relates to consent. Ms Dudley-Jones submitted that the warning and content of it do not go to the very heart of the case. She submitted that the Tribunal can direct itself to ignore what it has heard if it needs to but that it does not need to. Ms Dudley-Jones submitted that this was not such a case that comes anywhere near the bar to apply Porter v Magill and recuse itself.
The Relevant Legal Advice

13. The Legally Qualified Chair (LQC) gave legal advice to the Tribunal in relation to this application. When reaching a decision as to whether the Tribunal should recuse itself, it will take into consideration:

(i) that both parties agree that the relevant legal test is set out as in paragraph (ii) below.

(ii) paragraph 102 of Porter, quoting from Lord Phillips MR in the case of Re: Medicaments (no 2) [2001] 1 WLR 700 with amendments by Lord Hope of Craighead:

"The court must first ascertain all the circumstances which have a bearing on the suggestion that the judge is biased. It must then ask whether those circumstances would lead a fair-minded and informed observer, having considered the facts, would conclude that there was a real possibility that the tribunal was biased."

In that case, Lord Hope concluded that an auditor’s conduct at a press conference giving provisional findings did not demonstrate there was a real possibility that he was biased.

(iii) the case of R v Sutton Coldfield Magistrates’ Court [2006] EWHC 307 where Owen J made the following observations obiter:

"Where an application is made to adduce bad character evidence before a Magistrates Court, the Justices will, of necessity, hear details of the conviction in order to rule on the application. If the application fails they will put the convictions out of mind when they hear the case. The fact that they know the details of the previous convictions does not disqualify them from discharging their role as fact finders in the trial."

(iv) the oral submissions made to the Tribunal today on behalf of Dr Dighton and the GMC.

14. The above legal advice was amended at paragraph (iii) following submissions from the parties. Mr Brassington maintained his position that he did not agree with paragraph (iii) of the above advice. He stated that he did not agree with this proposition because it was not the ratio of the case and the comments made did not arise out of the facts of the Sutton Coldfield Magistrates’ Court case. The test to apply in this instance was Porter. The LQC and Ms Dudley-Jones did not dispute that the test to apply was Porter. The LQC amended her legal advice to ensure that it
was clear that the observations of Owen J in the *Sutton Coldfield Magistrates’ Court* case were obiter.

**Tribunal’s Decision**

15. The Tribunal noted that it first had knowledge of the warning, prior to the hearing, on its reading of the advance hearing bundle that was agreed between the parties. The reference to the "warning" was contained in (i) a letter Dr Dighton had written to Dr H dated 23 June 2017 and included in his exhibits in the hearing bundle, (ii) in the chronology prepared by and included in the expert report. Mr Brassington accepted it was his error that the letter 23 June 2017 was in the ‘agreed bundle’.

16. The Tribunal had regard to the two preliminary applications by the GMC, at Annex A and B, that it had considered in this case and the legal advice set out above.

17. With regard to Annex A and the GMC’s application to amend the Allegation, the Tribunal noted that it had decided it would have been prejudicial to Dr Dighton if the GMC had been permitted to amend its case to allege that he had been subject to an active warning in respect of similar conduct when he acted as alleged in paragraphs 2 to 7 of the Allegation. It determined that any such charge should have been included in the Allegation at an earlier stage and not sought on the first day of a hearing. The Tribunal was of the view that the Allegation should stand or fall on the facts as alleged in paragraphs 1 to 7. The prejudice to Dr Dighton was the GMC’s intention to alter its case on Day 1 of the hearing to include a suggestion that the warning evidenced a propensity to act as alleged and to infer that he had breached that warning.

18. Annex B is the Tribunal decision regarding the GMC’s second preliminary application to admit the content of the warning, a letter by Dr Dighton and references to the warning in the hearing bundle as background information. The Tribunal declined that application as the fact and content of the warning did not meet the relevance test in relation to the Tribunal’s decision making at the facts stage. It concluded that the fact that Dr Dighton had a warning was irrelevant. The determination on facts at stage 1 should be made on the evidence before it and the warning would have no impact on its decision.

19. In reaching conclusions in its previous determinations, the Tribunal had considered each paragraph of the Allegation. It looked again at the charges in the Allegation carefully, as to how the warning could impact or influence its decision at stage 1. The Tribunal did not consider that the warning would have any bearing on its considerations as to the facts, even if the content of the warning had been admitted into evidence. It remained the Tribunal’s position that the warning has no relevance or bearing on any decisions it may have to make at the facts stage, should
this be reached. The Tribunal was of the view that it would not be drawing on past conduct regarding other patients in any consideration of the facts but would be looking at the evidence before it to determine if the GMC has discharged its burden of proof.

20. The Tribunal reminded itself that the evidence upon which the Allegation was based is documentary as set out in the hearing bundle, a single statement from a doctor able to identify the relevant documentary evidence filed, which has not yet been disclosed to the Tribunal, and an expert report. Mr Brassington has already declared that there is no statement from Dr Dighton nor will he be called to give oral evidence nor is there a statement from Patient A. The live evidence for the purposes of the determination of facts will therefore be very limited.

21. In deciding whether the Tribunal should recuse itself, it had regard to what the fair-minded and informed observer would conclude in this case, as set out in the case of Porter. A fair-minded and informed observer reserves judgment until he or she has seen and fully understood both sides of the argument.

22. There is a presumption in favour of the impartiality of the Tribunal that it will act fairly, taking into account that, in this case, it is a professional body. The Tribunal was mindful that it is composed of trained professional Tribunal members, accustomed to making decisions of this kind. It is able to put information, such as the warning, out of its mind to give proper consideration to the facts in this case. The Tribunal determined that it would not be prejudiced by evidence it has already and very firmly decided to set aside.

23. The Tribunal has already set out in unequivocal terms that the warning will have no bearing on its decision-making at stage 1 because it is irrelevant. This point was conceded by Mr Brassington in his submissions regarding the GMC’s second application. The balance of probabilities test, which will be applied to any disputed parts of the Allegation, will be determined on the basis of the factual documentary evidence before the Tribunal. The Tribunal will be assisted as to whether there was a ‘failure’ of the doctor to adhere to GMP by the expert. The charges within the Allegation do not require an analysis of mental motivation or past conduct but an assessment of documents such as medical records and correspondence. The expert will offer a view as to the standards expected of a doctor and whether, in this instance, they were adhered to or not.

24. The Tribunal therefore determined that a fair-minded and informed observer would not conclude that there was a real possibility that this Tribunal was biased by its knowledge of the warning. The application by Mr Brassington, for the Tribunal to recuse itself, is refused.

ANNEX D - 07/03/2019
Application under Rule 17(2)(g)

1. At the end of the GMC case, Mr Brassington, on Dr Dighton’s behalf, made an application under Rule 17(2)(g) of the Rules, which states:

"the practitioner may make submissions as to whether sufficient evidence has been adduced to find some or all of the facts proved and whether the hearing should proceed no further as a result, and the Medical Practitioners Tribunal shall consider any such submissions and announce its decision as to whether they should be upheld”.

2. This application related to paragraphs 1(a)(i) and (ii); 1(c)(i) and (ii); 2(b); 3(a)(b) and (c); 3(e); 4(a) and (b); 6(b)(i) to (iv); and 6(f)(i) to (iii) of the Allegation.

Submissions on Dr Dighton’s behalf

3. Mr Brassington submitted that there was insufficient evidence in respect of the above outstanding paragraphs of the Allegation and they should proceed no further.

4. Mr Brassington referred to the case of R v Galbraith [1981] 73 Cr App R 124, as follows:

"If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty - the judge will stop the case. The difficulty arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence.

Where the judge concludes that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict on it, it is his duty, on a submission being made, to stop the case. Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witnesses reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence on which the jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury.”

5. Mr Brassington referred to the case of R v Shippey [1988] Crim LR 767, about taking the GMC case at its highest but not “taking out the plums and leaving the duff behind”.
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6. As to the burden and standard of proof, Mr Brassington submitted that the burden of proof is on the GMC and that, if there is no evidence that discharges its burden, then those sections of the Allegation must fall.

7. Mr Brassington referred to Lord Nicholls’ comments in the case of Re H (Minors) [1996] AC 563, that:

"The balance of probability standard means that a court is satisfied an event occurred if the court considers that, on the evidence, the occurrence of the event was more likely than not. When assessing the probabilities the court will have in mind as a factor, to whatever extent is appropriate in the particular case, that the more serious the allegation the less likely it is that the event occurred and, hence, the stronger should be the evidence before the court concludes that the allegation is established on the balance of probability... Built into the preponderance of probability standard is a generous degree of flexibility in respect of the seriousness of the allegation."

8. In relation to the drawing of inferences, Mr Brassington referred to the case of Soni v GMC [2015] EWHC 364 (Admin) and submitted that before an inference can be drawn the Tribunal has to be able to safely exclude, as less than probable, other possible explanations for Dr Dighton's conduct.

9. Mr Brassington submitted that there was no evidence, or insufficient evidence, for the Tribunal, properly directed, to find the above paragraphs of the Allegation proved. He stated that his submissions were predicated on the basis of the absence of evidence from Patient A.

Paragraph 1(a)(i) and (ii)

10. Mr Brassington stated that Dr Dighton has to meet the allegations as they are drafted. With regard to this sub-paragraph of the Allegation, he stated that the relevant wording was "in that you did not ask Patient A". Mr Brassington submitted that the Tribunal should not be concerned about what was, or was not, in the GP records or what would have been available to the GP. He submitted that this was solely focused on what passed between Dr Dighton and Patient A during the consultation on 1 November 2011 and that the Tribunal has no evidence on this point. Mr Brassington submitted that the GMC has attempted to plug the gap in the evidence but it cannot. He submitted that the GMC expert witness, Dr D, cannot say what passed between Dr Dighton and Patient A during that consultation. The Tribunal simply cannot allow this sub-paragraph of the Allegation to continue in circumstances where the GMC bears the burden of proof. He submitted that the absence of evidence does not equal evidence.

Paragraph 3(a) and (b)
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11. Mr Brassington submitted that he repeated the above submissions in relation to these sub-paragraphs of the Allegation. He referred to the wording used, "in that you did not ask Patient A". He stated that a failure to do what is alleged could not be considered in the absence of evidence from Patient A.

Paragraph 3(c)

12. Mr Brassington stated that the implementation of an adequate and appropriate treatment plan, for which there had been much questioning of Dr D, was of no consequence. He submitted that this sub-paragraph of the Allegation related to an alleged failure to assess, relying on sub-paragraphs 3(b) above. Mr Brassington stated that it was a criticism based on something not occurring. He submitted that, when looking at what is actually alleged against Dr Dighton then the GMC bears the burden of proof and it cannot discharge it.

Paragraph 4(a)

13. Mr Brassington submitted that he made the same submissions in relation to this sub-paragraph of the Allegation, in relation to the wording "you did not ask". He submitted that the GMC has not discharged the burden of proof on this point.

Paragraph 6(b)(i) to (iv)

14. Mr Brassington submitted that the evidence required by the GMC in respect of this sub-paragraph of the Allegation would be what passed between Dr Dighton and Patient A. He submitted that there was no evidence with regard to 6(b)(i), 6(b)(iii) and 6(b)(iv). In relation to 6(b)(ii) he stated that there was evidence but that all of the evidence was against the GMC case, namely that Patient A tried alternative painkillers but they did not provide analgesic relief. Mr Brassington submitted that the GMC bears the burden and it cannot discharge it.

Paragraph 6(f)(i)

15. With regard to the failure to regularly assess Patient A’s mental state and suicide risk, Mr Brassington submitted that there was an absence of records but that Dr D agreed with him that the absence of evidence cannot equal evidence of absence. He submitted that the GMC cannot discharge its burden.

Paragraphs 1(c)(i) and (ii), 2(b), 3(e), 4(b) and 6(f)(iii)

16. Mr Brassington stated that these sub-paragraphs of the Allegation all relate to a failure to inform Patient A’s GP. He stated that it was a precondition of informing other healthcare professionals in an adult with mental capacity, that a doctor needs consent to breach that confidentiality. He stated that if there is no consent a doctor may not breach confidentiality unless it is a life threatening situation. Mr Brassington

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stated that the GMC has to show that Patient A provided consent and submitted that, without it, the GMC cannot discharge the burden that rests upon it.

Paragraph 6(f)(ii)

17. Mr Brassington stated that this sub-paragraph of the Allegation was amended to read that the prescriptions were issued without appropriately referring Patient A to mental health services. He stated that Dr D agreed that the referral that was made was appropriate. Mr Brassington stated that Dr D had speculated as to why the referral was made but agreed that she could do no more than speculate as to Dr Dighton’s motivation. He submitted that there is no reference to motivation in the sub-paragraph. He submitted that the GMC cannot discharge the burden that rests upon them.

18. On both limbs of the test in Galbraith, Mr Brassington submitted that the above paragraphs of the Allegation should not proceed further.

In response to Ms Dudley-Jones’ submissions

19. Mr Brassington confirmed that his application was made under both limbs of the test set out in Galbraith, as above. Firstly whether there is any evidence at all and then, that there is, at its highest, insufficient evidence for the relevant sub-paragraphs to be proved. Mr Brassington stated that the drawing of inferences is relevant and the Tribunal should properly have reference to the case law in this regard.

20. Mr Brassington confirmed that it was not his submission that without a patient the GMC cannot prosecute a case. He submitted that the Allegation is worded in such a way that reliance is placed on consultations between Dr Dighton and Patient A to which there are no witnesses. In this case Patient A is not giving evidence and there are no other witnesses. There is insufficient evidence.

21. With reference to the supplementary report from Dr D, Mr Brassington submitted that this was effectively abandoned by Dr D following his questioning of her. He submitted that Dr D had been clear that, in relation to her saying it would be unusual not to note the medical history, this was speculative and could not assist the Tribunal in drawing a conclusion.

22. The GMC invite the Tribunal to infer that there is ongoing consent. There is no evidence of ongoing consent.

23. Mr Brassington also submitted that Ms Dudley-Jones’ submissions as to the frequency that Patient A was seen by NHS practitioners and resulting referral cannot assist the Tribunal.
24. Ms Dudley-Jones distinguished Soni, which referred to inference but not at the stage of no case to an answer. She submitted that it was inappropriate to quote that case at this stage in the proceedings. Ms Dudley-Jones stated that the Tribunal are entitled to draw inferences from evidence that might support the GMC case at this stage.

25. Ms Dudley-Jones submitted that Mr Brassington’s application was opposed.

26. Ms Dudley-Jones referred to Mr Brassington’s submissions in respect of sub-paragraphs 1(a)(i) and (ii), 2(b), 3(a), 4(a), 6(f)(i) and (ii) that they could not be safely determined in the absence of Patient A given the wording “you did not ask Patient A”. She submitted that Mr Brassington was wrong that, just because Patient A has not been called to give evidence, the Tribunal cannot know what occurred in the consultations. Ms Dudley-Jones stated that, whilst it is right that the Tribunal cannot know what was said in the consultations, the Tribunal does not need to hear from Patient A in order to determine that there is sufficient evidence. She submitted that there were many cases successfully brought before the MPTS where the patient mentioned was not called.

27. Ms Dudley-Jones submitted that the Tribunal did have some evidence before it to support these sub-paragraphs of the Allegation. She referred to Dr Dighton’s handwritten medical notes of consultations with Patient A of 10 and 13 October 2016. Ms Dudley-Jones stated that, where there were absences in the notes, this does not mean that there is insufficient evidence for this to be considered. It may be that Dr Dighton gives evidence at a later stage of these proceedings and may say that, whilst he did not record it in the notes, he did ask questions of Patient A. Ms Dudley-Jones submitted that the Tribunal is only looking at the sufficiency of evidence at this stage and that the medical notes are sufficient at this stage.

28. Ms Dudley-Jones referred to Dr Dighton’s handwritten records of his consultations with Patient A and to an entry for 1 November 2011. She stated that it is known that this was the first time that Patient A consulted with Dr Dighton. Ms Dudley-Jones referred to Dr D’s evidence that, if that record was all that was recorded, then Dr Dighton did not obtain an adequate history and he should have asked Patient A about her past medical history and current medication. Ms Dudley-Jones stated that Dr D identified that these were essential parts to inform a diagnosis and were of particular importance as Dr Dighton did not have a copy of Patient A’s GP records or a referral letter from her GP.
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29. Ms Dudley-Jones submitted that there was a prima facie case as to what happened in the consultation room on that date due to the handwritten note as it reflects a consultation between Dr Dighton and Patient A.

30. Ms Dudley-Jones referred to the controlled drug management chart completed by Dr Dighton on 10 August 2017. There he recorded the ‘start date’ for controlled drugs as 1 November 2011. Dr D, in evidence, stated that it would have been strange not to record Patient A’s past medical history if he had asked about it.

Paragraph 3(a) to (c)

31. Ms Dudley-Jones submitted that the Tribunal also has Dr Dighton’s handwritten records of his consultations with Patient A in relation to these sub-paragraphs of the Allegations.

32. With regard to the consultation on 10 October 2016, Ms Dudley-Jones submitted that there is clearly sufficient evidence, at this stage, that Patient A was not asked about her mood, anxiety levels, sleep, nor was she adequately assessed and examined as to her mood, speech and suicidal ideation.

33. Ms Dudley-Jones referred to the note made by Dr Dighton in his handwritten records that Patient A was “stable with drug use... no need for psychiatric referral”. She submitted that the absence of further notes allows the tribunal to draw a proper inference at this stage that Dr Dighton did not ask the relevant questions as alleged in sub-paragraphs 3(a) to (c). Ms Dudley-Jones stated that this was not to say that Dr Dighton might later give evidence to say that he did ask the relevant questions and did not record them, but that this was for consideration at a later stage.

Paragraph 4(a)

34. With reference to this sub-paragraph of the Allegation, Ms Dudley-Jones submitted that the same applies as above. She referred to Dr Dighton’s handwritten records of his consultation with Patient A on 13 October 2016.

Paragraph 6(b)(i) to (iv)

35. Ms Dudley-Jones stated that this related to the issuing of prescriptions for co-proxamol between 5 January 2017 and 10 October 2017 where it is alleged that Dr Dighton did not adequately assess Patient A’s pain, explain that it was unlicensed or try alternative painkillers. Ms Dudley-Jones submitted that Dr Dighton did not try different painkillers. She stated that there were no handwritten records made by Dr Dighton of any consultations on the dates that the prescriptions were issued in this time period. She stated that the handwritten records from 1 November 2011 to 12 April 2014 and then July 2016 appear without discernible gaps. Ms Dudley-Jones
submitted that the Tribunal may draw the inferences that there were no records missing.

36. Ms Dudley-Jones stated that the only handwritten record that may correlate to the issuing of a prescription was on 31 August 2017; however there was no prescription for co-proxamol issued in August 2017. In the absence of handwritten records of the consultations, Ms Dudley-Jones submitted that the Tribunal could draw the inference that he failed to assess or explain the risks of taking co-proxamol or that it was unlicensed. She submitted that the absence of records was sufficient evidence at this stage such that the Tribunal could find there is a case to answer.

Paragraph 6(f)(i)

37. With reference to this sub-paragraph of the Allegation, Ms Dudley-Jones submitted that the same applies as above. She stated that, on the various dates in Schedule 5, there are no notes in the handwritten records. Ms Dudley-Jones submitted that there was sufficient evidence to allow the Tribunal to proceed to a determination of the facts.

Paragraphs 1(c)(i) and (ii), 2(b), 3(e), 4(b) and 6(f)(iii)

38. With regard to failing to inform Patient A’s GP, Ms Dudley-Jones referred to Mr Brassington’s submissions that there was a precursor that the GMC has to prove that Patient A provided her consent for Dr Dighton to do so. Ms Dudley-Jones submitted that the Tribunal is looking at the sufficiency of evidence and that there is cogent evidence before the Tribunal to say that Dr Dighton did have consent, on numerous occasions, to write to Patient A’s GP. She noted an entry in the handwritten records on 28 July 2016 "to write to GP, address to be obtained by patient". Ms Dudley-Jones referred to the evidence of Dr D that there is no evidence that he did inform the GP on that occasion. She submitted that it may be that Dr Dighton may later say that he did not have consent from Patient A and the Tribunal will then have to determine the case on the evidence.

39. Ms Dudley-Jones referred to Dr D’s evidence that if there was no communication with the GP then this fell below the expected standard due to the risk of prescribing without knowing what another practitioner may have been issuing. Ms Dudley-Jones also referred to Dr D’s comments that there is no evidence on the papers that consent was not given by Patient A. Ms Dudley-Jones submitted that, given the positive evidence that Dr Dighton had consent to inform Patient A’s GP, the Tribunal has sufficient, indeed ample, evidence on this point.

40. Ms Dudley-Jones referred to the instances in Patient A’s medical records that detail any form of contact between Dr Dighton and Patient A’s GP. This included a telephone call on 12 April 2012 to the GP, with subsequent notes made and a letter sent also on 12 April 2012; a letter to Patient A dated 10 April 2012 in which
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Dr Dighton stated that he had recently been in contact with Patient A’s GP; reference in the handwritten records dated 28 July 2016 to Dr Dighton intending to write to Patient A’s orthopaedic surgeon; a letter dated 28 July 2016 sent to all patients taking sleeping tablets where he would write to the GP about prescriptions.

41. Ms Dudley-Jones referred to email correspondence from Dr Dighton to Dr C on 31 August 2017. Dr Dighton wrote that “there has been no clinical need to contact him [GP] further” [i.e. since 12 April 2012]. She stated that there was no suggestion that he did not write to the GP due to a lack of consent. Ms Dudley-Jones submitted that this suggests that Dr Dighton always had Patient A’s consent. She also stated that the questionnaire completed by Patient A for Dr Dighton in 2018 made no reference to any refusal of consent.

Paragraph 6(f)(ii)

42. Ms Dudley-Jones referred to Mr Brassington’s submissions that there was insufficient evidence as Dr D agreed that the referral of Patient A to mental health services in 2017 was appropriate. Ms Dudley-Jones referred to Dr D’s evidence that there had been no referral until 2017, and even then the referral did not make reference to any assessment or issue with Patient A’s mental health. Dr D was concerned Patient A was severely depressed and it was unclear why Dr Dighton decided to refer her. Ms Dudley-Jones referred to Dr D’s comments that Dr Dighton had been written to by NHS England by this point. Further that the letter following the referral showed that Patient A had needed to see a psychiatrist. On 10 October 2016 Dr Dighton records “no need for psych referral”; and this is in keeping with the fact of no referral.

43. Ms Dudley-Jones referred the Tribunal to Patient A’s NHS medical records. She submitted that there had been frequent occasions when Patient A had been seen by secondary psychiatric services, referred by her GP, and took the Tribunal to a number of instances where this can be seen in the records.

The Chair’s Legal Advice

44. The Legally Qualified Chair reminded the Tribunal that the burden of proof is on the GMC who brings the case and the standard of proof is the balance of probabilities.

45. With regarding to inferences that may properly be drawn from the evidence, the LQC stated that the case of Soni was relevant. When drawing inferences the Tribunal must be mindful that it has been able to safely exclude, as less than probable, any other possible explanations for the charges against Dr Dighton.

46. In this instance the Tribunal must consider the case put on behalf of the GMC and whether, taken at its highest, this Tribunal could properly find the facts alleged
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to be proven. Regarding inferences to be drawn from the evidence, the Tribunal would have to be satisfied that it could safely conclude that other explanations were less probable than that which is alleged in each of the charges of the Allegation against Dr Dighton, on which a submission of no case is sought.

47. Ms Dudley-Jones was concerned about the reference to the Soni case because it does not mention Galbraith and was concerned with the conclusions a Tribunal reached and not a sufficiency of evidence on submissions of no case to answer. Mr Brassington stated that he agreed with the legal advice from the LQC and that the case of Soni is relevant. The LQC confirmed that her legal advice would stay as drafted.

Tribunal’s Decision

48. The Tribunal noted that the charges on which the application for no case to answer was sought can be grouped into a number of categories:

   I. Paragraphs 1(a), 3(a), 3(b)(i), 4(a), 6(b)(iii) and (iv) which allege a failure by Dr Dighton to ask of or explain to Patient A about specific matters;
   II. Paragraphs 3(b)(ii), 3(c), 6(b)(i), 6(f)(i) which alleges that Dr Dighton did not assess Patient A;
   III. Paragraphs 1(c)(i) and (ii), 2(b), 3(e), 4(b), 6(f)(iii) which alleges that Dr Dighton did not communicate with Patient A’s GP;
   IV. Paragraph 6(f)(ii) which alleges Dr Dighton did not appropriately refer Patient A to mental health services;
   V. Paragraph 6(b)(ii) which alleges a failure by Dr Dighton to try alternative painkillers when prescribing co-proxamol.

I - Paragraphs 1(a), 3(a), 3(b)(i), 4(a), 6(b)(iii) and (iv)

49. The Tribunal observed that the GMC regularly pursues cases in the absence of a patient who, had they attended, could have provided evidence material to the case. However, these particular paragraphs of the Allegation are drafted in a way that relies upon a knowledge of what Dr Dighton asked Patient A. It noted that no one witnessed the consultations between Patient A and Dr Dighton. Patient A has not given evidence to this Tribunal and the Tribunal only has Dr Dighton’s handwritten records as to what took place. The Tribunal has no evidence, either way, as to whether the handwritten records were full or incomplete; indeed Dr Dighton has made admissions at paragraph 7 of the Allegation as to poor record keeping, which may indicate that the relevant records are not comprehensive.

50. In relation to 1(a), the Tribunal has before it the evidence of Dr D that it would be appropriate to record past medical history and current medication, especially as Patient A did not come to Dr Dighton via a referral from another doctor.
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Whilst it would be an unlikely proposition that Dr Dighton would see a new patient and not make some enquiry into her past medical history, the Tribunal has to determine what was asked by Dr Dighton of Patient A and it has no evidence in this respect.

51. With respect to paragraphs 3(a) and (b)(i), the Tribunal had regard to Dr Dighton’s handwritten records. The Tribunal noted that Dr Dighton could have asked Patient A and not recorded her responses; could have asked and recorded it elsewhere; or not asked at all. The Tribunal was mindful that it was being invited to speculate which it could not do. There was a question mark as to whether Dr Dighton’s handwritten records were a complete record. There was no other evidence for the Tribunal to assist it in this regard.

52. The Tribunal only has evidence of what was recorded, not of what was said in the consultations. It has no means of determining what Dr Dighton asked. The same arguments pertain to sub-paragraph 4(a).

53. The Tribunal noted that paragraph 4 relates to the date 13 October 2016. The handwritten recording is unclear. The month denoted as ‘10’ could be a ‘12’. At that consultation, Dr Dighton recorded a need for a blood test. The blood test results had a sample date of 13 December 2016 and Dr Dighton, in the controlled drug patient management report, referred to blood test results taken on 13.12.2016 and a "hypothyroid" handwritten note from that consultation date. The Tribunal found that whether it was October or December makes no difference to its decision in relation to this application.

54. In relation to sub-paragraphs 6(b)(iii) and (iv), the Tribunal determined that the wording "explain" was similar to "ask", and the arguments set out above apply.

55. The Tribunal determined that there is no case to answer on 1(a), 3(a), 3(b)(i), 4(a), 6(b)(iii) and 6(b)(iv).

II - Paragraphs 3(b)(ii), 3(c), 6(b)(i), 6(f)(i)

56. Paragraph 3(b)(ii) requires the Tribunal to determine whether it was likely than not that Dr Dighton did not assess Patient A’s mood, speech, anxiety levels, communication and suicidal ideation. The Tribunal had regard to Dr Dighton’s handwritten records for 10 October 2016, which state that there was "no need for psych [psychiatric] referral" and considered that this suggested that Dr Dighton had undertaken an assessment. The Tribunal concluded that there was some evidence but that the evidence undermines the GMC case and, accordingly, there is no case to answer.

57. With regard to sub-paragraph 3(c), the Tribunal had determined that Mr Brassington’s application of no case to answer had been successful in relation to
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3(b)(i) and 3(b)(ii). The Tribunal was of the view that 3(c) was predicated on sub-paragraphs 3(b)(i) and 3(b)(ii). The Tribunal also noted that there was evidence to suggest that a treatment plan, of sorts, had been completed by Dr Dighton, contrary to the GMC case. There is therefore insufficient evidence for the GMC to prove its case.

58. With regard to sub-paragraph 6(b)(i), the Tribunal considered whether, when issuing prescriptions, Dr Dighton failed to adequately assess Patient A’s pain. The Tribunal noted that there was a handwritten record of a consultation on 16 June 2017 but that it was unknown if Patient A was present. It corresponds with a letter received by Dr Dighton from Dr C on the same date. The Tribunal questioned what evidence there was in relation to Dr Dighton’s assessment of Patient A’s pain. It noted that this did not appear to be mentioned in Dr Dighton’s handwritten records and that a referral to a pain clinic only took place in 2018, which is outside of the date range as alleged. The Tribunal took account of a letter from Dr Dighton to Patient A dated 30 October 2017, which appears to show that Dr Dighton had not recorded a consultation with Patient A on 27 October 2017 in his handwritten records. That suggests that not all consultations were recorded. The Tribunal does not have evidence in the medical records that Dr Dighton was assessing Patient A’s pain but there is evidence that, at least once, he did not record a consultation. The Tribunal considered how likely it was that it would find this sub-paragraph proved when he was prescribing co-proxamol for Patient A’s painful shoulder throughout this period. The Tribunal determined that there was not sufficient evidence, taking it at its highest, for the GMC to prove its case.

59. With regard to paragraph 6(f)(i), the Tribunal noted that Dr Dighton’s clinical notes are sparse and suggest that no regular assessment was taking place. The absence of evidence is, in this instance, evidence because of the regularity of his prescribing. He should have either been assessing her mental state regularly or making a referral to mental health services and reflecting the same in her medical notes.

60. According to the evidence provided to the Tribunal, Dr Dighton prescribed the following medications to Patient A between 5 January 2017 and 10 October 2017:

- Co-proxamol 1600 tablets;
- Diazepam 604 tablets;
- Zolpidem 588 tablets;
- Mirtazapine 240 x 45mg tablets and 392 x 15mg tablets;
- Dihydrocodeine 1274 tablets.

61. The Tribunal considered whether Dr Dighton’s pattern of prescribing had the hallmark of repeat prescriptions without regularly assessing Patient A’s mental state and suicide risk.
The possibilities the Tribunal considered were that Dr Dighton regularly assessed Patient A but did not record it; Dr Dighton did not regularly assess Patient A; Dr Dighton assessed Patient A but recorded it elsewhere. The Tribunal noted the need to regularly assess Patient A’s mental state and suicide risk given the medication he was prescribing. Dr D’s evidence was that this would be a more in-depth assessment.

The Tribunal determined that there was sufficient evidence such that the facts in question could, on one view of the evidence, be found proved. It determined to refuse Mr Brassington’s application under Rule 17(2)(g) in relation to sub-paragraph 6(f)(i).

III - Paragraphs 1(c)(i) and (ii), 2(b), 3(e), 4(b), 6(f)(iii)

The Tribunal had regard to Mr Brassington’s submissions that in order to discharge their burden of proof, the GMC must provide evidence that Patient A had given consent to the sharing of her medical information between Dr Dighton and her NHS GP. Mr Brassington further submitted that the GMC had failed to adduce evidence that consent was in place at the material time.

The Tribunal therefore assessed the evidence before it in relation to Mr Brassington’s two propositions: first, whether consent was required for Dr Dighton to communicate with Patient A’s GP and second, whether there was any evidence of Patient A’s consent, explicit or implicit, during the material time.

The Tribunal had regard to the principles of consent, confidentiality and a duty to act in Patient A’s best interests, assisted by the guidance in paragraph 44(a) of GMP, paragraphs 8 to 10 and 24 to 35 of the GMC’s Confidentiality Guidance (2009), and of paragraphs 9 to 15 of the GMC’s Confidentiality Guidance (2017). The Tribunal was of the view that, in routine practice, there is a positive onus on every doctor to communicate with other health professionals, where it is in the patient’s best interests to do so.

The Tribunal then had regard to a number of instances where Dr Dighton told Patient A that he was going to communicate with her GP. No mention of any objection to consent by Patient A is mentioned in the evidence before the Tribunal. There appears to have been implied consent.

The relevant instances include:

- Telephone conversation with Patient A’s GP on 12 April 2012;
- Letter from Dr Dighton to Patient A’s GP also 12 April 2012;
- Letter to Patient A dated 10 April 2012;
- Handwritten records by Dr Dighton of his intention to contact the GP on 12 April 2012;
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- Notice to all patients taking sleeping tablets dated 28 July 2016, which included Patient A, and in which Dr Dighton sets out his obligations that "Good Practice necessitates doctors communicating with one another";
- Email from Dr Dighton to NHS England on 31 August 2017, in which he stated that there had been no clinical need for him to contact Patient A’s GP further: "I can confirm that Patient A’s GP is aware of my co-proxamol prescribing. I had a full discussion with the GP on 12 April 2012. It was then agreed that I continue to prescribe co-proxamol for Patient A I have not had any concerns about para-suicide, or overdosing, during the time I have overseen her care; and because her renal function has remained normal, and he would not himself be prescribing them, there has been no clinical need to contact him further."

69. Having determined that a lack of evidence of explicit consent is not a barrier to the GMC in discharging its burden, and having found that the GMC have adduced evidence of implicit consent, the Tribunal went on to assess the evidence of what communication had taken place between Dr Dighton and Patient A’s NHS GP.

70. The Tribunal noted that these sub-paragraphs encompass a wide time frame from 2011 to 2017 and that the above communication relates to that period. It was of the view that there was some evidence that could enable the GMC to discharge its burden of proof. Whilst the Tribunal can accept that a letter may have gone astray occasionally, taken together, the Tribunal determined that there was sufficient evidence such that the facts alleged could, on one view of the evidence, be found proved. It determined to refuse Mr Brassington’s application under Rule 17(2)(g) in relation to sub-paragraph 1(c)(i) and (ii), 2b, 3(e), 4(b), 6(f)(iii).

IV - Paragraph 6(f)(ii)

71.Prescriptions were issued in the time period, 5 January 2017 to 10 October 2017, before a referral took place on 23 June 2017. The Tribunal had regard to Dr Dighton’s handwritten record on 10 October 2016 that he had noted that there was no need for psychiatric referral. The Tribunal has inferred that there was no referral in the early months of 2017.

72. On 23 June 2017 when Dr Dighton did refer Patient A to a psychiatrist, Dr G, it was not for an assessment but for an opinion about her usage of medication. Prior to 23 June 2017, in conjunction with Dr Dighton’s record on the controlled drug patient management report dated 10 August 2017, he noted he had made two referrals to mental health, one on 16 August 2012, and another on 23 June 2017. This is evidence that in the interim he made no referrals and yet continued to prescribe large quantities of medication.

73. The Tribunal also noted that the referral to Dr G on 23 June 2017 makes no reference to referring due to Patient A’s depression. On 31 August 2017 Dr Dighton,
in an email, records "her sedative drugs were the primary reason for referral at the time". Dr Dighton was prescribing anti-depressants to Patient A. He makes no mention of any assessment of Patient A or that she was suffering from depression in his referral letter. Dr D gave evidence that the referral on 23 June 2017 was an appropriate referral. However, the Tribunal noted the repeat prescriptions issued prior to that date.

74. In conclusion, the Tribunal determined that there was sufficient evidence such that the facts in question could, on one view of the evidence, be found proved. It determined to refuse Mr Brassington’s application under Rule 17(2)(g) in relation to sub-paragraph 6(f)(ii).

V - Paragraphs 6(b)(ii) to (iv)

75. The Tribunal’s approach in assessing the evidence in relation to paragraph 6(b)(ii) was predicated on its view that "try alternative painkillers" connoted the stopping of co-proxamol and substituting it with an alternative painkiller.

76. The Tribunal noted that the allegation relates to a ‘failure’ to try alternative painkillers. The Tribunal considered it would not be a failure if there was information that alternatives had been tried in the past and did not work.

77. The Tribunal identified a number of instances in Patient A’s medical records when there was reference to other painkillers having been tried but that they did not work. It had regard to a letter dated 15 May 2018 from Dr K, Consultant in Pain Medicine & Anaesthesia, in which he stated that co-proxamol had been the only drug that seemed to help Patient A’s pain. Further, the Tribunal had regard to the replies completed by Patient A in the questionnaire from Dr Dighton from early 2018, in which Patient A mentions other drug alternatives that had not worked. Dr Dighton was aware in early 2018 that Patient A had tried other alternatives but that only co-proxamol had worked. The Tribunal considered that it was reasonable that she would have told Dr Dighton this at some point during 2017 but it has no evidence either way in this regard.

78. The Tribunal determined that in order to prove a failure on Dr Dighton’s part for not having tried alternative painkillers, the GMC must establish that he had a duty to do so. The evidence in this instance points in the other direction: there is evidence that alternative painkillers had previously been tried, but to no avail. The Tribunal accordingly determined that there is no case to answer.

79. The following paragraphs remain to be determined: 1(b), 1(c)(i) and (ii), 2(b), 3(e), 4(b)(i) and (ii), 6(f)(i) to (iii).

ANNEX E - 07/03/2019
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Application under Rule 17(6)

1. In relation to sub-paragraph 6(c)(ii) of the Allegation, Mr Brassington referred to the oral evidence of Dr D that this sub-paragraph was duplicitous of sub-paragraph 6(c)(i) of the Allegation. When asked, Ms Dudley-Jones stated that the GMC position was that Mr Brassington would have to make an application for it.

2. The Tribunal was of the view that, as the GMC was not withdrawing this sub-paragraph of the Allegation, Mr Brassington’s submissions to ask for this sub-paragraph to be removed would fall under Rule 17(6) of the Rules.

Submissions on Dr Dighton’s behalf

3. Mr Brassington referred to the evidence from the expert, Dr D, that this sub-paragraph was duplicitous, as it is a repetition of what was contained within 6(c)(i). He submitted that this sub-paragraph should not proceed.

GMC Submissions

4. Ms Dudley-Jones submitted that the GMC did not oppose Mr Brassington’s submissions in this respect given Dr D’s evidence on this point in that it was duplicitous.

Tribunal’s Decision

5. The Tribunal had regard to the oral evidence from Dr D and agreed that she had stated that sub-paragraph 6(c)(ii) was duplicitous. The Tribunal determined to amend the Allegation by deleting sub-paragraph 6(c)(ii). It determined that it could make this amendment without injustice to Dr Dighton as it removes an allegation, and there is no injustice to the public interest as the content of the sub-paragraph is said to be duplicitous and already included in paragraph 6(c)(i), which was admitted by Dr Dighton at the start of this hearing.

ANNEX F - 15/03/2019

Application for adjournment

1. Following the announcement of the determination on impairment, the Tribunal considered whether it could start to hear submissions on the question of sanction on 14 March 2019.

2. Both parties asked for time until 15 March 2019 to give their submissions. The GMC indicated that their submissions would take about an hour and Mr Brassington indicated he would need two hours and possibly longer. Neither party were ready to
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proceed on the afternoon of 14 March 2019. Ms Dudley-Jones needed instructions as to the sanction the GMC was seeking. Mr Brassington sought more time to prepare in the light of the Tribunal’s determination on impairment.

3. The Tribunal indicated that its preference was to hear such evidence and submissions as were relied upon by the parties and reach its decision on 15 March 2019. If that were not possible then the Tribunal would consider an adjournment.

4. On 15 March 2019 the Tribunal again sought the time estimates of each party in the knowledge that Ms Dudley-Jones had by then advised Mr Brassington of the sanction the GMC would be seeking. She maintained that she would take about an hour and Mr Brassington indicated that he would be not less than two hours and that it was now his intention to adduce live evidence.

5. The Tribunal considered that, in fairness to Dr Dighton, any delay should be as short as possible, in particular:

   a. The Tribunal has spent three weeks hearing evidence in this case and it is stressful for Dr Dighton to have these proceedings further delayed.

   b. The principle of justice and the right to a fair hearing: The Tribunal noted that unwarranted delay rarely adds to the fairness of a hearing. The proposed date for this hearing to reconvene would be October 2019, some seven months away.

   c. Timings: The Tribunal has heard the time estimates from both parties as to submissions on sanction and the joint suggestion that all matters should ideally be heard in one instance. It indicated its intention, in the light of the time estimates suggested, to hear any evidence and submissions today and record its decision between today and two further days, 28 and 29 March 2019. The Tribunal offered to reconvene for half a day to deliver its decision and hear any applications, if appropriate, for an immediate order.

6. The Tribunal indicated to the parties that time would need to be set aside today to hear any application, if appropriate, regarding the need for an interim order. In the event there are any other applications in the matter, the MPTS Case Manager shall, if possible, liaise with member of this Tribunal.

7. Ms Dudley-Jones told the Tribunal that she had instructions from the GMC which she had communicated to Mr Brassington. In the circumstances Mr Brassington had agreed for her to communicate those instructions to the Tribunal. The Tribunal is not invited to consider an interim order and in the circumstances, the GMC invite the Tribunal not to deal with it.
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8. Mr Brassington then made a formal application for an adjournment of the sanction stage to the next available date.

Submissions on Dr Dighton’s behalf

9. Mr Brassington referred to the Tribunal’s indication on 14 March 2019 that it did not think it was appropriate to proceed today unless it could complete the matter. He submitted that he relied upon this.

10. Mr Brassington stated that the Tribunal’s proposal would not be an adequate time slot to hear evidence and submissions from both parties. He submitted that Dr Dighton will give evidence at the sanction stage as a consequence of the Tribunal’s determination on impairment, including paragraphs 97 onwards. He stated that this was the direct result of the concern by the Tribunal of Dr Dighton’s lack of apology and lack of insight. Mr Brassington stated that, as a result, this will require additional work on his part and on the part of his instructing solicitors. He submitted that he was not in a position to call Dr Dighton to give evidence now.

11. In reliance upon the Tribunal’s indication, Mr Brassington submitted that they were not ready today and invited the Tribunal to adjourn this hearing. He stated that he understood the Tribunal’s indications that it has made in wanting to proceed today. Mr Brassington submitted that if it were required for this hearing to continue today then there would be a denial of justice as the preparation of evidence cannot be completed in time and Dr Dighton will be significantly disadvantaged.

12. Whilst the delay is regrettable, Mr Brassington submitted that there has been no delay in this case due to Dr Dighton’s conduct. He submitted that it would not be proper that Dr Dighton is denied the opportunity to properly present his case as he has not had time to do so. Mr Brassington submitted that an adjournment was proportionate and appropriate in those circumstances.

GMC Submissions

13. Ms Dudley-Jones had regard to the Tribunal’s position as at 14 March 2019 in that if the matter could not be started and completed in one day then the matter would likely go off to a time when both parties could be heard. She submitted that she was conscious that Dr Dighton’s representatives planned to call Dr Dighton to give evidence.

14. When agreeing to the joint suggestion, Ms Dudley-Jones submitted that the Tribunal must been seen to finish a process without pressure of time. She submitted that it was regrettable that the hearing is at the end of a three week period but she was aware that the time required would not be restricted to submissions only.
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15. Ms Dudley-Jones submitted that she agreed with the Tribunal regarding avoiding delay but that, with the time needed for evidence and submissions, the hearing would nevertheless have to be adjourned part heard. The Tribunal must be seen to be doing this fairly.

Tribunal’s Decision

16. The Tribunal had regard to paragraph 29(2) of the Rules:

"Where a hearing of which notice has been served on the practitioner in accordance with these Rules has commenced, the Committee or Tribunal considering the matter may, at any stage in their proceedings, whether of their own motion or upon the application of a party to the proceedings, adjourn the hearing until such time and date as they think fit."

17. The Tribunal recognise that fairness requires that Dr Dighton be given the optimum opportunity to present his submissions and any evidence he chooses to provide for the Tribunal to take into consideration and that this be conducted in least pressure of time constraints.

18. This Tribunal, anxious to facilitate the timely conclusion to proceedings, were willing to hear evidence and submissions today and to reconvene on 27/28 March 2019 or 23/24 April 2019. Regrettably the earliest date that Counsel for the GMC and Dr Dighton are available for one day is not until July 2019.

19. The earliest date when the Tribunal and both parties are available for two days is 28 to 29 October 2019.

20. The Tribunal noted Mr Brassington’s submission that he was not prepared to proceed today due to the Tribunal’s indication yesterday that it would either hear all the evidence with time to complete its decision today or adjourn to another date. Mr Brassington, as a consequence of that, has not prepared a witness statement for Dr Dighton, nor prepared for Dr Dighton to give oral evidence today. The Tribunal find that regrettable, particularly bearing in mind that this has been a three week hearing and Mr Brassington has had all that time to make those preparations should he have chosen to do so. It is disappointing to the Tribunal to learn, on the last scheduled day of the hearing, that he had not made those preparations. Of course the Tribunal draw no adverse inference against Dr Dighton, but in the light of the lack of preparation and to ensure this does not arise in the future, the Tribunal have made the directions set out below, pursuant to Rule 16(1A)(b) and Rule 16(6) of the Rules.

21. The directions will best enable the Tribunal to take into consideration Dr Dighton’s thinking and attitude towards the Allegation and the Tribunal’s determination on facts and impairment at a time nearest to those determinations
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being delivered. In the event that Dr Dighton wishes to prepare an addendum witness statement, closer to the time of the reconvened hearing, the Tribunal would expect it would be filed no later than 4 October 2019 at 4pm.

1. The application for adjournment is granted.

2. In the event that Dr Dighton gives live evidence at the reconvened hearing, a witness statement shall be served on the GMC and MPTS no later than 29 March 2019 at 4pm.

3. Any other evidence Dr Dighton seeks to rely on shall be filed no later than 4 October 2019 at 4pm.

4. Each party shall file a time estimate for their evidence and submissions no later than 4 October 2019 at 4pm.

5. This matter is adjourned part heard until 28 October 2019, to the same Tribunal. The Tribunal anticipate that the hearing should only take two days, but to ensure there is no further delay has allocated a third day. The hearing is therefore listed from 28 to 30 October 2019.

6. In the event of any further applications being made in regard to these proceedings, the MPTS Case Manager shall, if possible, liaise with a member of this Tribunal.
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**Record of Determinations – Medical Practitioners Tribunal**

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### Medical Practitioners Tribunal

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