# PUBLIC RECORD

**Dates**: 19/05/2025 - 11/06/2025

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| **Doctor:** | Dr Richard THOMPSON |
| **GMC reference number:** | 3199699 |
| **Primary medical qualification:** | BM BCh 1987 Oxford University |

| Type of case | Outcome on facts | Outcome on impairment |
|---|---|---|
| New - Misconduct | Facts relevant to impairment found proved | Impaired |

**Summary of outcome**

No action

**Tribunal:**

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| Legally Qualified Chair: | Mr Robin Ince |
| Lay Tribunal Member: | Mr Tim Skelton |
| Registrant Tribunal Member: | Dr Nagarajah Theva |

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| Tribunal Clerk: | Ms Hinna Safdar<br>(19/05/2025 - 21/05/2025)<br>Ms Racheal Gill<br>(22/05/2025 - 03/06/2025)<br>Miss Emma Saunders<br>(04/06/2025 - 11/06/2025) |

**Attendance and Representation:**

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| Doctor: | Present, represented |
| Doctor's Representative: | Mr Ben Rich, Counsel, instructed by Gordons Partnership Solicitors |
| GMC Representative: | Mr Christopher Rose, Counsel |

**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.

## 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 - 04/06/2025

## Background

1. Professor Thompson qualified with BM BCh in 1987 from the University of Oxford. Prior to the events which are the subject of the hearing, Professor Thompson became an Honorary Consultant Paediatric Hepatologist at King's College Hospital NHS Foundation Trust in 2003. In 2008 he became the Clinical Lead in Liver Molecular Genetics at King's College Hospital NHS Foundation Trust and since 2015 he has been a Professor of Molecular Hepatology at King's College London. At the time of the events Professor Thompson was practising as a Consultant Hepatologist at Kings College Hospital, London ('the Hospital')

2. On 26 July 2021, Martha (Martha Mills, referred to as 'Patient A' in the Allegation) had accidently slipped whilst riding her bike in Wales, which caused her upper abdomen to collide with the handlebar, the impact resulting in a grade 4 pancreatic laceration. The pancreas lies central in the upper abdomen, immediately in front of the spinal column and the blunt trauma to the upper abdomen had caused the pancreas to crush against her spine. In addition to the transection of the head of her pancreas, Martha also suffered a laceration to her left kidney. Martha initially attended a local 'minor injuries' department and was seen but discharged. Later in the evening, Martha presented to Bronglais Hospital in Wales and was transferred to the University Hospital in Cardiff. On 28 July 2021 Martha was then transferred to the Rays of Sunshine Ward ('the ward') at the Hospital, one of three locations in the UK specialising in the treatment of paediatric pancreatic injuries. Throughout the next month, Martha remained as an inpatient on the ward. The injury to her pancreas was treated conservatively - it was decided that the potential, life-long, side effects of a surgical removal of the disconnected section of pancreas outweighed the benefits of removing it - but her recovery was slow and marked by pancreatic fluid (a mixture of digestive enzymes and insulin) collecting around the head of the pancreas, and by repeated fevers.

3. Just under a week prior to 29 August 2021, Martha was suffering from a fever with a raised heart rate. She continued to suffer from a build-up of fluid at the head of the

pancreas; she had the stent (which was intended to connect the head of the pancreas with its disconnected section) that had been inserted to address this replaced; and she had a Peripherally Inserted Central Catheter ('PICC') line inserted into a vein. This latter point was of significance because the PICC line was ultimately considered to be a likely source of the infection to which Martha ultimately succumbed. During the following days, Martha continued to experience spikes in temperature, i.e. in excess of 38 degrees. She also suffered from significant bleeding at the site of the PICC line and she experienced significant pericardial effusion. Her antibiotic prescription was changed from Tazocin as she was believed to have suffered an allergic reaction to it (such manifesting itself in the form of a skin rash).

4. Martha's condition continued to deteriorate, and she was transferred to Paediatric Critical Care on 30 August 2021 and was subsequently referred to Great Ormond Street Hospital for Extracorporeal Membrane Oxygenation ('ECMO') treatment, which is an invasive and highly specialised form of life support that uses a machine to supply oxygen to the blood outside the body. This was unsuccessful and withdrawal of intensive care support was agreed with her family. ECMO was discontinued at 04:15 and Martha died at 04:20 on 31 August 2021, aged 13.

5. At the Coroner's Inquest on 25 February 2022, the Senior Coroner for Inner North London concluded that Martha's medical cause of death was: "*1a) Refractory shock caused by 1b) Sepsis caused by 1c) Pancreatic transection operated* (sic) *caused by 1d) Abdominal trauma*".

6. Professor Thompson was the on-duty consultant for the Rays of Sunshine ward on 13 August, and again on 29 August (from 09.00) and on 30 August 2021. Martha had, by 29 August 2021, been an inpatient on the ward for over a month. Professor Thompson conducted a mid-morning ward round on that day during which he saw Martha, and he left the Hospital around 15.00 but remained on call.

7. The allegation that has led to Professor Thompson's hearing arises from his medical treatment of Martha on 29 August 2021, namely his management of her deteriorating condition on that day.

8. The GMC alleges that, on 29 August 2021, Professor Thompson failed to provide adequate care and treatment to Martha in that he did not: recognise or respond to Martha's hypotension; initiate further intravenous fluid resuscitation; escalate Martha to the Paediatric Intensive Care Unit (PICU) for a clinical review; or, in the alternative, discuss Martha with the Microbiology Department regarding the overall antibiotic management of Martha.

9. It is further alleged that Professor Thompson failed to conduct an in-person review and assessment of Martha's condition, including a new rash which had developed in the afternoon of 29 August 2021; and did not adequately communicate with Dr B in the PICU team in that he provided Dr B with incorrect lactate and blood pressure readings and did not include Martha's most recent rash in his discussions with Dr B.

10. Following Martha's death, a Serious Untoward Incident ('SUI') review was carried out by the Trust responsible for the Hospital, which is usual practice following any untoward incident or death. This resulted in a Serious Incident Investigation Report ('SIIR') the final version of which was dated 16 February 2022.

11. The concerns were raised with the GMC on 16 March 2022 by Martha's parents.

## The Outcome of Applications made during the Facts Stage

12. The Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to amend the Allegation at paragraphs 1(b) and 1(c)(ii). The amendment was to include the words "*which had developed that day"* after the word "*rash*" to clarify which rash (the previous rash that Martha had displayed a few days earlier, or the new rash) was being referred to. The application was not opposed by Mr Rich, Counsel on behalf of Professor Thompson. The Tribunal was satisfied that the amendment could be made without injustice. It was also satisfied that the amended application better reflected the evidence upon which the Allegation is based. It therefore decided to grant the application and amend paragraphs 1(b) and 1(c)(ii) of the Allegation, in accordance with the proposed amendments set out below.

## The Allegation and the Doctor's Response

13. The Allegation made against Professor Thompson is as follows:

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

1. On 29 August 2021, you failed to:
    a. appreciate the severity of Patient A's physiological derangement and take more aggressive intervention from 12:00-13:00 in that you did not:
        i. appropriately recognise and respond to Patient A's hypotension;
        To be determined
        ii. initiate further intravenous fluid resuscitation;

To be determined

iii. escalate Patient A to the Paediatric Intensive Care Unit ('PICU') team for a direct clinical review;
To be determined

iv. in the alternative to a PICU referral, discuss Patient A with the Microbiology Department regarding the overall antibiotic management of Patient A, including the administration of intravenous antifungal agents and/or the antimicrobial regime;
To be determined

b. conduct a direct in-person review and assessment of Patient A, including Patient A's rash, which had developed that day, from approximately 17:00 onwards; Amended under Rule 17(6)
To be determined

c. adequately communicate with Dr B in the PICU team during your call at 21:41 in that you:

i. provided Dr B with an incorrect:

1. systolic blood pressure reading of 100mmHg given that Patient A's systolic blood pressure had been below 100mmHg since 14:00;
To be determined

2. serum lactate reading of 1.5mmol/l which was taken at 13:39 when Patient A's most recent serum lactate reading taken at 17:40 was 2.4 mmol/l;
To be determined

ii. did not include Patient A's rash, which had developed that day, in your discussions with Dr B. Amended under Rule 17(6)
To be determined

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

14. No facts were admitted at the hearing.

## The Facts to be Determined

15. In light of the above, the Tribunal had to make a determination in relation to each of the disputed paragraphs of the Allegation, as set out above.

## Witness Evidence

16. The Tribunal received oral and written evidence on behalf of the GMC from the following witnesses:

- Ms C, Paediatric Nurse Practitioner at the Hospital, by video link; together with her witness statement 23 May 2024.
- Dr B, Consultant in Paediatric Intensive Care at the Hospital, by video link; together with his witness statement dated 5 December 2024.

17. Professor Thompson provided his own witness statement, dated 8 April 2025 and also gave oral evidence at the hearing. In addition, the Tribunal received evidence from the following witnesses on Professor Thompson's behalf:

- Professor D, Consultant of children's liver disease at the Hospital, by video call; together with his witness statement dated 10 April 2025.
- Dr E, Clinical Director for Children's services at the Hospital, by video call; together with her witness statement dated 10 April 2025.

## Expert Witness Evidence

18. The Tribunal also received oral and written evidence from an expert witness, Professor F, Consultant Paediatrician and Consultant Paediatric Intensivist. He provided an expert witness report dated 10 June 2023, together with a clarification letter dated 23 May 2024 and a supplemental report dated 5 January 2025.

19. Professor F concluded in his report that the following aspects regarding Professor Thompson's actions were seriously below the standard expected of a reasonably competent consultant:

*"The aspects of care delivered by Professor Thompson that I would consider to be seriously below the standard include; his failure to appreciate the severity of [Martha]'s physiological derangement on 29 August 2021, his failure to escalate [Martha] for a Paediatric Critical Care review on 29 August 2021 and his provision of an inaccurate account of [Martha]'s clinical status to the on-call Paediatric Intensivist at 21.41 on 29 August 2021. Professor Thompson's*

*failure to escalate [Martha] for a Paediatric Critical Care review and to communicate the seriousness of [Martha]'s condition to her parents on 29 August 2021 were apparently due to his flawed understanding of her physiological status.*

*…*

*The overall standard of care was seriously below the standard expected of a reasonably competent Consultant. From 12.00 on 29 August 2021, despite a clinical context of suspecting sepsis, Professor Thompson did not recognise that [Martha] was suffering from significant hypotension in association with fever and a new rash, which was not responsive to intravenous fluids. It should have been evident to any reasonably competent Consultant that [Martha] was suffering from significant physiological derangement and required more aggressive intervention with further intravenous fluid resuscitation and a referral to the PICU team.*

*In addition, when Professor Thompson did discuss [Martha] with the PICU team he provided outdated, incorrect and misleading information. Had he provided accurate information regarding [Martha]'s physiological status, the patient would almost certainly have received more aggressive resuscitation and been admitted to the Paediatric Critical Care Unit."*

## Documentary Evidence

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

- Martha's medical records, dated July to August 2021.
- Professor Thompson's account of events given to the Serious Incident Review, dated 21 September 2021.
- Serious Incident Investigation Report ('SIIR') (redacted), dated 16 February 2022.
- Transcript of parts of the Inquest into Martha's death, dated 25 February 2022.

## The Tribunal's Approach

21. 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. Professor Thompson does not need to prove anything. 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 events occurred.

22. The Tribunal had regard to the detailed written submissions provided by parties, on which they also elaborated orally.

23. The Tribunal was aware that, when considering factual disputes, it should start with known or provable facts, and contemporaneous documents, and not give undue weight to uncorroborated oral evidence or witness demeanour. The Tribunal has noted the submissions of Mr Rich who referred to the cases of *Dutta* [2020] EWHC 1974 (Admin) and *Khan* [2021] EWHC 374 (Admin). Both *Dutta* and *Khan* rely on *Gestmin* from which *Khan* extracted the following principles [at para 39]:

*"We believe memories to be more faithful than they are. Two common errors are to suppose (1) that the stronger and more vivid the recollection, the more likely it is to be accurate; (2) the more confident another person is in their recollection, the more likely it is to be accurate.*

*Memories are fluid and malleable, being constantly rewritten whenever they are retrieved. This is even true of 'flash bulb' memories (a misleading term), i.e. memories of experiencing or learning of a particularly shocking or traumatic event.*

*Events can come to be recalled as memories which did not happen at all, …*

*The process of civil litigation itself subjects the memories of witnesses to powerful biases. Considerable interference with memory is introduced in civil litigation by the procedure of preparing for trial. Statements are often taken a long time after relevant events and drafted by a lawyer who is conscious of the significance for the issues in the case of what the witness does or does not say.*

*The best approach from a judge is to base factual findings on inferences drawn from documentary evidence and known or probable facts. "This does not mean that oral testimony serves no useful purpose... But its value lies largely... in the opportunity which cross-examination affords to subject the documentary record to critical scrutiny and to gauge the personality, motivations and working practices of a witness, rather than in testimony of what the witness recalls of particular conversations and events"*

24. The Tribunal is entitled to take account of Professor Thompson's good character: firstly on the basis that it supports his credibility and therefore can be taken into account when deciding whether to believe him; and secondly, on the basis that because of his good character, he is less likely than otherwise of committing the alleged conduct. However, it is not determinative.

25. The Tribunal took into account the case of *Re B (Children) (Care Proceedings: Standard of Proof) (CAFCASS intervening)* [2008] 3 WLR 1: [2009] 1 AC 11, which provided that:

*"in general, the more serious the allegation…the more cogent will be the evidence for which a tribunal will be looking. In some cases it will need to look at the facts more critically or anxiously.*

*However this does not require a different standard of proof. Essentially, in such circumstances, a tribunal needs to subject the evidence relied upon by the GMC to a critical, anxious and heightened scrutiny…"*

26. The Tribunal is entitled to consider inconsistencies in witness evidence when deciding how much weight to give it. Even if there are unresolved inconsistencies, it does not automatically follow that a witness is not telling the truth, it may merely show that the evidence of a witness is unreliable. Minor inconsistencies on peripheral points will not significantly affect the credibility of a witness if the main parts of their account are consistent. The Tribunal will only decide facts relevant to the allegations and will avoid speculation or considering evidence that was not presented. It will base its findings strictly on the evidence that is before it.

27. Hearsay evidence is admissible but must be treated with caution. For example, Dr G's written entry into the medical records on 30 August 2021 is admissible even though he did not give live evidence. The more remote or layered the hearsay (e.g., third-hand accounts), the less weight it will carry. Live evidence is not automatically preferred over hearsay - but reasoned justification must be provided if hearsay is preferred.

28. The Legally Qualified Chair (LQC) advised the Tribunal that there are essentially four allegations from 29 August 2021, which allege that Professor Thompson failed to:

1. Appreciate the severity of Martha's physiological derangement;
2. Take more aggressive intervention from 12:00 and 13:00;
3. Conduct a direct, in-person review of Martha and her new rash from 17:00 onwards;
4. Adequately communicate with Dr B of the PICU team during a 21:41 phone call.

29. The GMC must establish not only what occurred but also that Professor Thompson had a duty to act as alleged.

30. Regarding paragraphs 1(a)(i) to (iv), Mr Rose submitted that the GMC must also prove at least one of the following, namely Professor Thompson's:

- Failure to recognise/respond to hypotension;
- Failure to initiate further IV fluid resuscitation;
- Failure to escalate to PICU;
- Failure to consult Microbiology regarding antibiotics/antifungals.

31. The LQC also advised that the Tribunal was required to assess these points individually and as potential failings under paragraph 1(a). He further agreed with Mr Rose's

suggestion that the Tribunal should first determine whether Martha's condition showed *"severe physiological derangement"*, and if it did, whether Professor Thompson appreciated that severity and failed to take more aggressive intervention from 12:00 to 13:00 on 29 August 2021. The Tribunal noted that the alleged failure to appreciate the severity of Martha's physiological derangement only extended to him not appropriately recognising and responding to Martha's hypotension.

32. The LQC also referred to the test from *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. A medical practitioner is not negligent if their conduct aligns with a responsible body of medical opinion, even if others would have acted differently. This is relevant in assessing whether Professor Thompson's *"stepped"* approach was reasonable in contrast to Professor F's advocated *"aggressive"* treatment strategy.

33. Regarding paragraph 1(b), the Tribunal noted that there is no factual dispute that Professor Thompson did not conduct a direct, in-person review after 17.00 on 29 August 2021. The issue is whether he was under a duty to do so.

34. In paragraph 1(c), the GMC must prove two specific sub-allegations:

- That Professor Thompson provided incorrect systolic blood pressure and serum lactate readings; and
- That he failed to mention Martha's most recent rash in his discussion with Dr B.

35. Only if one or both are proved will the Tribunal assess whether there was a failure to *"adequately communicate",* which it interpreted to mean communicating *"to a satisfactory or acceptable extent".*

36. The Tribunal will consider the expertise, reasoning, objectivity, and evidential basis of Professor F's views, and will assess whether his conclusions are consistent and well-supported.

37. The Tribunal will bear in mind the evidence provided to the Inquest into Martha's death but will disregard its conclusions, which addressed different questions and relied on different evidence. Similarly, it will disregard previous and current media coverage of Martha's case and focus solely on the evidence presented in this hearing.

38. The Tribunal acknowledges the tragic nature of the case and the emotional toll it has had on witnesses and on Martha's family. However, it resolved to consider the matter dispassionately.

## The Tribunal's Analysis of the Evidence and Findings

39. The Tribunal has considered each paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts. However, where there were subparagraphs based on one incident, the Tribunal found it necessary to consider the whole incident in context.

Chronology

40. Before doing so, however, the Tribunal decided to set out the relevant facts of this case by way of a chronology. It considered it appropriate to begin with Martha's condition on the previous day, Saturday 28 August 2021.

Saturday 28 August 2021

41. The Tribunal noted that, throughout the day, Martha's Heart Rate varied from a high of 125 BPM to a low of 93 BPM but otherwise was less than 120 BPM. Her Respiratory Rate varied from a high of 28 to a low of 20. Her systolic blood pressure was generally at 100 or more, only falling below that figure to 98 at 11:00. It reached a high of 109 at 22:00 hours and was recorded at 106 at 02:00. Martha's oxygen saturation levels were 100 going down to a low of 96. Her Bedside Paediatric Early Warning Scores (BPEWS) scores ranged from 2 to 4, being mainly 3. Her temperature was consistently over 38° throughout the day, in excess of 39° on five occasions and only falling below 38° on two occasions, at 09:00 hours and 22:00 hours. It was recorded at 37° at 02:00 hours on 29 August 2021.

Sunday 29 August 2021

42. Martha's Heart Rate was recorded as 113 at 09:00, 116 at 10:00, and 123 at 11:00. Respiratory rates for the same times were 22, 27 and 27. Her blood pressure was recorded as dropping from 106 at 02:00 hours to 84/43 at 09:00, 87/ 40 at 09:15, 93/55 at 09:30, 97/56 at 10:00, 97/79? at 10.15 and 77/39 at 11:00. Her BPEWS scores were 4 at 09:00 and 4 at 10:00 and her temperature was 39.2° at 09:00, 36.9° at 10:00 and 39.3° at 11:00.

43. The Tribunal pauses there to note that Professor F, in his report (at paragraphs 2.128 and 2.129) referred to Dr G's evidence given at Martha's Inquest, as follows:

"*At the subsequent inquest,* [Dr G]*, Paediatric Specialist Registrar, stated that his understanding of [Martha]'s case as he came on duty on 29 August 2021, was that he was;*

*'aware that she had come to the hospital with a severe pancreatic injury and had a transection. During the time I felt she had quite a complex course and had been aware of the week preceding in that she had been having high fevers, having antibiotics changed. I believe the week earlier at handovers we had been discussing [Martha] had problems with the significant bleeding from her PICC and drain site and also that she had a possible reaction to her Tazocin antibiotic at one point as well that week. I was also aware that they had been discussing with the radiology team and surgical team about her pancreatic collections and whether these could be the source of her fevers or not'*.

*…At the subsequent inquest,* [Dr G] *stated that during the morning ward round of the ROS Ward on 29 August 2021,* [Dr R] *informed the team that [Martha]'s blood pressure had fallen.* [Dr G] *requested a 10 ml/kg intravenous fluid bolus be administered and noted that her blood pressure improved. He also stated that in view of nursing concerns regarding fevers coinciding with use of the PICC line, the Consultant team made a plan to stop using the PICC line for the day except with Teicoplanin antibiotic and in between that, still lock it with ethanol line lock, but not to remove the PICC line'*."

44. From this extract, the Tribunal concludes that Dr G was the person who initiated the administration of the bolus, which appears to have been administered at around 11:00. Martha's immediate subsequent readings were as follows: her Heart Rate was 122 BPM at 12 noon, 112 at 13:00 and 106 at 14:00. Her Respiratory Rates were 26 at 12 noon, 24 at 13:00 and 23 at 14:00. Her blood pressure rose to 97/47 at 11:15, 97/ 46 at 12 noon, 91/ 44 at 1300 and 102/ 56 at 1400. Her temperature dropped to 37.8° at 12 noon and was approximately 37.5° at 1400.

45. Professor F also referred to Professor Thompson's evidence at the Inquest, stating that he:

"*Saw Martha midmorning on the course of the ward round with* [Dr I]*, the Consultant Surgeon, and we were struck by her continued spiking fevers and the fact that morning she was tachycardic, she was in the process of having 10ml/kg of saline at that time because of that, and her blood pressure which had sagged. As you also know, she was not acidotic and clinically her perfusion was good and that was reinforced by the blood gas which suggested that she was systemically coping, despite the fact that she was clinically unwell. There was no, apart from giving her extra fluids, there was no other intervention that either of us felt that she needed for that. Clearly, apart from the fact that she was unwell our concerns were the fact that we didn't know the cause and she certainly was behaving like she had inflammatory process, an infective process driving it. As you know we have not got anything from the cultures and the two most likely sources of inflammation or infection were the site of the*

*trauma in her abdomen where there was a collection and a drain in situ or indeed whether it was the peripheral PICC line'...*

*Regarding the decision not to remove the PICC line, Professor Thompson stated; 'We had a long conversation on that subject and we arrived at a compromise as you've heard which was to not use it other than give antibiotics and in between that try sterilising it. This is something that we do very often. If we did remove PICC lines every time we were concerned about infection they would be rendered much less useful than they are, so it wasn't unreasonable. I still don't believe it's an unreasonable decision to make. In light of subsequent events, I regret it because I am still very concerned that it was the line that was the problem, but at the time it was a perfectly reasonable decision…'*

*Professor Thompson has summarised his conversation with* [Dr I]*, the Consultant Surgeon, regarding a possible infective process; 'We didn't know the source and, as you probably also heard and I now reiterate, is that her CRP for instance, which is a sensitive marker for inflammatory processes, had improved and was half what it had been, white cell count was slightly up that morning compared to the day before but, again, it was markedly less than it had been during the week. Obviously, as you also know, she had antibiotics increased and she was on a very broad spectrum variety of antibiotics. We were absolutely, and I believe, infection was the root cause and we were treating that and treating her systemically with fluids'…*

*Regarding escalation of Martha to the HDU or PICU, Professor Thompson has stated that; 'We had been giving her some fluid and, clearly, if she hadn't responded to that and if she had required more fluid shortly after that, if she had shown other signs of peripheral constriction with worse blood gas etc then that would have been an indication to move her'."*

46. In his oral evidence, Professor Thompson confirmed that his discussion with Dr I, the Consultant Surgeon, lasted about 30 minutes.

47. The Tribunal further notes that Professor F, in his report (at paragraphs 2.135 and 2.136) referred to Dr G's additional evidence given at Martha's Inquest, as follows:

"*At the subsequent inquest,* [Dr G] *has stated that after the completion of the morning ward round; '*[Dr R] *went back to review [Martha] following the bolus and during his review she had two green bilious vomits and asked me to come and review her as a result. When I came to see [Martha] at the time [around 13.00-13.30], she had a sick bowl in her hands and was being up lots of kind of foamy spit. I felt her tummy at the time which I described as being soft and didn't show any signs of distension and when I listened to it bowel sounds were present. I*

*asked her about whether she had passed any wind or opened her bowels which she said she had been that morning. At that time she developed a new rash across her torso, her neck, her arms, her elbows and her thighs which I described as a maculopapular rash'*

…[Dr G] *has stated that because the rash was itchy he didn't think it was linked to sepsis and that it was more likely to have been caused by a drug reaction."*

48. From this extract, the Tribunal concludes that Dr G was aware of the new rash at around 13:00 to 13:30 hours, although it appears that he did not communicate this to Professor Thompson until around 17:00, some hours later that afternoon.

49. At 13:39, the results of a blood gas test indicated that Martha's lactate level was 1.5, which was described as *"normal"*. Professor F recorded that:

"[Dr G] *has stated that the results of this blood gas test didn't make him suspicious about sepsis*."

50. At around 15:00 hours, Professor Thompson left the hospital and returned home, although he remained on call and could be contacted by telephone.

51. During the afternoon, no readings regarding Martha's medical condition are recorded as having been taken. Her medical chart is silent as regards the period 14:00 to 16:45. Readings recommenced at around 16:45 as follows. Martha's Heart Rate is recorded at 131 BPM at 16:45, 126 at 17:00, 126 at 18:00, 113 at 19:00, 111 at 19:15, and 122 at 20:00. Her Respiratory Rate is recorded as 36 at 17:00 hours, 36 at 17:45, 25 at 19:00, and 26 at 20:00. Her blood pressure is recorded as 87/? at 17:00, 84/? at 18:00, 92 at 1815, 94 at 19:00 and 93/52 at 20:00. Her BPEWS scores were up to 8 at 1700, 5 at 18:00, 4 at 19:00 and 5 at 20:00. Finally, Martha's temperature readings were 39.5° at 16:45, 39.5° at 18:00, 38.6° at 19:00, and 39.5° at 20:00.

52. Professor F, in his report (at paragraphs 2.139 to 2.143) states as follows:

"[Dr G] *has stated that he was asked to review [Martha] again at around 17.00 because of her rash spreading. He has stated that he; 'Reviewed [Martha]'s bloods and had tried to look back through the notes, I had become concerned about a condition called Dress Syndrome and I had spoken to Professor Thompson about the possibility of speaking to Dermatology and I phoned them. I got through to the Dermatology Registrar but they had actually finished their shift at the time of the call'...*

*Professor Thompson has summarised his phone call with* [Dr G] *at around 17.00; 'She [Martha] was tachycardic and had a low blood pressure and we decided to give her a second bolus fluid and we discussed the rash, which you have heard him describe and which I did not see and my information is based on what he has told you personally. My conclusion from that discussion was very much that I kept an open mind. I have put it in my statement that I was not at all convinced this was DRESS syndrome, although I was keeping an open mind on that, and whether this was in fact sepsis or something else I very much kept an open mind. As I say, we decided to give her some more fluid to which she again produced which seemed to be a reassuring response'.*

[Dr G] *has stated that the Dermatology Registrar said that one of their team would review [Martha] the following day and recommended a topical steroid cream.* [Dr G] *has stated that [Martha]'s mother asked that topical steroids were not started until the Dermatology team has reviewed the patient...* [Dr G] *has stated that he told [Martha]'s mother at the time of his 17.00 review that he thought the rash; 'could be a delayed reaction to the Tazocin antibiotic from earlier in the week as some of her bloods and clinical features were reflective of the possible Dress Syndrome as some of the features of that can be a high fever, can have a blanche [sic] maculopapular rash and she had a raised ESP blood count reflected in one of her liver blood tests was raised as well. Looking at her other bloods from that day, the CRP was coming down, the total white cell count was 13.1 which was in the normal range and neutrophil count was only slightly raised at 9'...* [Dr G] *has stated that [Martha]'s mother raised the possibility that the rash was a consequence of her having sepsis.* [Dr G] *has stated that; 'When I thought about [Martha]'s treatment, she was on broad spectrum antibiotics of the Meropenem and Teicoplanin, which I believe were increased I think on the 27th and she also had the antibiotics earlier that morning before I came on of the gentamicin. I looked at her bloods and, as I explained to you before about looking at the infection markers and her gas had been repeated as well at 17:38 which was fairly reflective of the gas beforehand with a similar pH and CO2 and her lactic had risen slightly to 2.4, but it could still be considered within the normal range although it had risen. I was concerned about [Martha]'s ongoing fever but because of the information that I had to hand, the negative microbiology, her bloods and her gas and the rash as it wasn't reflective of sepsis at that point'..."*

53. At 17:40, the blood gas test results indicated that Martha's Lactate level had risen to 2.4. As indicated in the previous paragraph, Dr G considered this still to be within the normal range.

54. Taking the above extracts into account, the Tribunal concludes that Dr G reviewed Martha at around 17:00, and shortly thereafter telephoned Professor Thompson, during which discussion they agreed to give Martha a second bolus and that Dr G would contact

dermatology. It further appeared to the Tribunal that, as the Lactate result only came in at 17:40, it is unlikely that this was discussed between Professor Thompson and Dr G during their telephone conversation at around 17:00.

55. Professor F, in his report (at paragraphs 2.147 and 2.148) states as follows:

*"*[Dr G] *has stated that he spoke to Professor Thompson again, probably before 20.30; 'We discussed [Martha] again because she had been having ongoing fevers and after the 5:00 p.m. review when we had given [Martha] a second fluid bolus she hadn't required a further fluid bolus but I was concerned at the time that, if she did, I felt that she would need escalation to Intensive Care. I had asked whether, in hospitals where I have previously worked there is a watcher system for children who are considered for the possible need for escalation where you can make Intensive Care aware of them so they have some of the details in case things change It doesn't always trigger review, but I had asked whether Intensive Care were aware of [Martha] from the events that she had been having during the week and I asked Professor Thompson if he could make the Intensive Care team aware of [Martha] and what had been happening to her'...*

*At the subsequent inquest, Professor Thompson stated that; 'Through the course of the day, as you know, we did that twice [administered intravenous fluid boluses] but on both occasions she appeared to improve in response to 10ml/kg which in terms of sepsis is still a very modest treatment'."*

56. Taking these extracts into account, the Tribunal concludes that Dr G telephoned Professor Thompson at around 20:00 to 20:30 during which they discussed Martha's fever and agreed that Professor Thompson would contact Dr B to alert PICU that a referral might be made later that evening if a third bolus had to be given. The Tribunal considers that it is more likely than not that, during such discussion, Dr G would have provided Professor Thompson with the up-to-date medical information including her most recent Lactate level of 2.4 and the readings that had been taken at around 20:00, namely Heart Rate of 122, Respiratory Rate of 26, Blood Pressure of 93/ 52, BPEWS score of 5, and temperature of 39.5°. The Tribunal further notes Professor Thompson's evidence that he cannot remember what figures were given to him by Dr G or whether he wrote them down.

57. The Tribunal is aware that, following this conversation, there was a deterioration in Martha's condition in that her Heart Rate increased to 135 BPM at 21:00, 133 at 22:00, 136 at 23:00 and 122 at midnight. Furthermore, her Respiratory Rate was 22 at 21:00, 28 at 22:00, 27 at 23:00 and 26 at midnight. Her Blood Pressure dropped to 85/46 at 20:45, was 90/42 at 21:00, 86/34 at 22:00, 92/32 at 23:00 and 102/51 at midnight. Her BPEWS scores

were 4 at 21:00 hours, 5 at 22:00, 5 at 23:00 and 4 at midnight. Finally, her temperature was 39.4 at 2100, 39.3 at 22.00 and 39 at midnight. No evidence or explanation has been given to the Tribunal as to why such deterioration did not prompt the administration of a third bolus which would have resulted in Martha being referred automatically to PICU. What is apparent is that Professor Thompson was not informed about this deterioration and therefore was unaware of the true situation.

58. Finally, as far as Professor Thompson is concerned, he spoke to Dr B at 21:41 by telephone. The content of their discussion will be analysed when the Tribunal comes to consider paragraph 1(c) of the Allegation below.

Paragraph 1(a) (stem)

1. *On 29 August 2021, you failed to:*
    a. *appreciate the severity of Patient A's physiological derangement…:*

59. The Tribunal accepted Mr Rose's suggestion that it first had to ascertain Martha's medical condition on 29 August 2021 and then decide whether it amounted to "*physiological derangement*". Once that question had been answered, it was then to go on and consider whether Professor Thompson "*failed to appreciate the severity of Patient A's physiological derangement and take more aggressive intervention*" with specific reference to sub-paragraph (i) "*in that you did not appropriately recognise and respond to Patient A's hypotension*". Once that question had been answered, the Tribunal was then to go on and consider whether Professor Thompson "*failed to…take more aggressive intervention from 12:00 – 13.00*" with specific reference to sub-paragraphs (ii) to (iv), as set out above.

60. Accordingly, the Tribunal first considered Martha's medical condition on 29 August 2021 and whether it amounted to "*physiological derangement*". The Tribunal notes that "*derangement*" is defined in an on-line dictionary as "*a disturbance in the regular order or normal functioning of something*".

61. The Tribunal notes that Professor Thompson does not dispute that Martha was experiencing physiological derangement. He acknowledged that she was clearly unwell; describes her as the sickest child on the ward; and confirms that he was seriously concerned about her condition. Martha's physiological derangement is documented across several medical records, as set out above in the chronology. These records show that she remained tachycardic through the day. Her temperature spiked at 09:00, 11:00, 17:00 and 18:00, before dropping suddenly at 19:00, after which it rose to previous levels at 20:00. She was hypotensive at 09:00 and again from 11:00 to 13:00. There are no recorded blood pressure

readings between 14:00 and 16:45, but from 17:00 onwards until midnight she continued to exhibit hypotension. Finally, her Lactate level rose from 1.5 at 13:39 to 2.4 at 17:40, although Professor Thompson was likely only aware of those readings at around 17.00 and 20.30 respectively.

62. The Tribunal is therefore satisfied that Martha's medical condition on 29 August 2021 amounted to "*physiological derangement*".

Paragraph 1(a)(i)

1. *On 29 August 2021, Professor Thompson failed to:*
    a. *appreciate the severity of Patient A's physiological derangement and take more aggressive intervention from 12:00-13:00 in that he did not:*
        i. *appropriately recognise and respond to Patient A's hypotension;*

63. Professor Thompson denied this allegation. In his GMC statement, he stated that:

*"I had appreciated in the morning, when I saw [Martha], that she remained unwell. I was concerned enough to have a lengthy discussion with my surgical colleague. The focus of our conversation was the origin of the ongoing inflammatory process. The differential included sepsis, possibly of origin in her intravenous line, or ongoing pancreatic leak/damage. By the time we saw her, she had already been given 10 ml/kg of IV fluid; to which she clearly had a physiological response. In the evening, she was again tachycardic, hypotensive and had a raised lactate. Approximately 12 hours after the first infusion she had another 10 ml/kg bolus.* [The Tribunal notes that this is an overestimation on Professor Thompson's part – the first bolus was administered at around 11:00 and the second at around 17:00, a period of 6 hours, not 12]. *Again, she had an immediate response. This was obviously not the end of the management that she required. However, during the night, I received no further calls from the hospital, and unfortunately, I assumed that that meant that she had remained stable. In fact, looking at her observations through the night, she seems to have remained stable until immediately before her syncopal collapse and subsequent rapid deterioration."*

64. On the morning of 29 August, Martha experienced a significant drop in blood pressure and suffered a period of hypotension around 09:00. However, the Tribunal considers that Professor Thompson's Team appropriately recognised the severity of this hypotension and responded in line with best practice by initiating a 10ml/kg intravenous fluid bolus at approximately 11:00. This intervention resulted in an immediate and measurable improvement in the Martha's physiological condition. Blood pressure readings increased promptly and remained stable - approximately 97 mmHg between 11:15am and 13:00, then

rising further to 102 mmHg by 14:00. This represented a positive and sustained response to treatment. Additional clinical indicators also improved. Martha's temperature had normalised to 37.5°C by 14:00, her oxygen saturation remained high at 99–100%, heart rate decreased from 123 to 106 bpm by 14:00, and respiratory rate reduced to 24 and then 23 breaths per minute at 13:00 and 14:00 respectively. The Tribunal therefore considered that, at 11:00, Professor Thompson and his Team appreciated the clinical severity and responded appropriately to the hypotensive episode. The outcomes suggest that at the time, the intervention was clinically effective.

65. The Tribunal considered it was important to note that this care took place in the context of Professor Thompson's continued involvement in Martha's case. He had previously been the on-call consultant on 13 August, had participated in multidisciplinary ward meetings concerning the patient every Tuesday, and had actively engaged with other consultants regarding her ongoing condition. For example, on 27 August 2021, he personally attended the hospital in the evening to speak with the on-call consultant, and followed up again the next day on 28 August 2021, with another discussion. Furthermore, on Sunday 29 August, he spent approximately 30 minutes discussing Martha's management with Dr I, Martha's surgical consultant, regarding both surgical options and potential sources of infection, which was thought to be an intravenous PICC line. Although Dr I was initially reluctant to remove the PICC line, they agreed on a compromise: the line would be flushed with ethanol and used solely for antibiotic administration. This demonstrated to the Tribunal that Professor Thompson was engaged with this case and as such appreciated the severity of Martha's physiological derangement.

66. Furthermore, the Tribunal noted paragraph 1.15.8 of the NICE guidelines on 'Suspected sepsis: recognition, diagnosis and early management' which stated, under the heading *"When to deliver a second bolus"*, *"Reassess the patient after completion of the intravenous fluid bolus, and if no improvement give a second bolus..."* (Tribunal emphasis added). The Tribunal considers that there was an improvement in Martha's blood pressure readings.

67. Accordingly, the Tribunal considers that, up to the time he left the hospital around 15:00 on 29 August 2021, Professor Thompson had taken all steps reasonably expected of a senior clinician to respond to hypotension, in accordance with NICE guidance.

68. Later that day, at around 17:00, Martha's blood pressure had dropped again to 87 mmHg, down from 102 mmHg at 14:00. A second bolus was administered around this time, some 6 hours after the first, resulting in a positive response: BP rose to 92 mmHg at 18:00, 94

mmHg at 19:00 and was 93 at 20.00. These readings suggest an appropriate and effective response to another episode of hypotension.

69. At approximately 20:30, Professor Thompson received a telephone call from Dr G. The context of this call followed an increase in temperature to 39.5° at 20:00, up from 38.6°, with a heart rate of 122 bpm, respiratory rate of 26, blood pressure at 93 mmHg, and oxygen saturation at 100%. The patient's BPEWS score was 5. These parameters were broadly consistent with earlier readings and, in the Tribunal's estimation, showed no significant prolonged acute deterioration sufficient to prompt the administration of a further bolus. Consequently, Professor Thompson did not authorise a third fluid bolus at that time. He did, however, advise that if further deterioration occurred - particularly of blood pressure - a third bolus should be given, followed by referral to the Paediatric Intensive Care Unit (PICU) for direct clinical assessment.

70. Following this call, further observations were recorded at 20:45, showing a drop in blood pressure to 85 mmHg, followed by a marginal recovery to 90 mmHg at 21:00 and another decline to 86 mmHg at 22:00. As stated above, the Tribunal noted that there was no evidence Professor Thompson was made aware of these deteriorating readings. Had he been informed of these values, the Tribunal was satisfied he would have acted promptly and in accordance with clinical standards.

71. The Tribunal noted Professor F's oral evidence that blood vessels lose their integrity, thereby reducing heart function, due to being physically damaged by infection, which in turn leads to insufficient blood circulation. To assist the patient's survival, blood circulation can be improved by rapidly infusing liquid into the blood vessels by means of a bolus. Professor F considered that the response to the 11:00 bolus was "*transient*" and that more intravenous fluids should have been introduced shortly after that first bolus. In cross examination, he agreed that the improvement in Martha's blood pressure from 77 to 97 within 15 minutes of the bolus was an improvement but was still "*not acceptable*" but gave no specific reason for considering that an improvement of 20mmHg in such a short time was insufficient. He acknowledged there had been a response to the second bolus but nonetheless maintained that a third bolus was needed at 19:00. Having said that, Professor F acknowledged that the decision when to administer fluids was a matter of judgement and was "*a very difficult task*" and, in his expert report, he also acknowledged that inflammatory markers in the morning were either improving or not worsening, supporting the view that Professor Thompson's early management was appropriate.

72. The Tribunal also notes Mr Rose's submissions which referred to Professor Thompson's evidence that he had been "*falsely reassured*" by the blood pressure readings

and that this amounted to a concession that he had not recognised and responded appropriately to Martha's hypotension. However, the Tribunal is not persuaded by this submission - it considers that Professor Thompson's comment has been made with the benefit of hindsight and that, at the specific times on 29 August 2021, he was entitled to derive some reassurance from the fact that there appeared to have been an immediate and sustained improvement in Martha's blood pressure following the administration of both boluses. It must not be forgotten that Professor Thompson also had the advantage of seeing Martha when he was present on the ward on 29th August 2021, which would have given him further information which was not available to Professor F. Finally, the Tribunal is also persuaded by Mr Rich's submissions on the point that, although Professor F's suggested *"aggressive approach"* was one appropriate way of dealing with the situation, it was not the only appropriate method - the "*stepped approach*" adopted by Professor Thompson was the practice on the ward at the time and was in line with NICE guidelines in that it was reasonable to see if one bolus would be sufficient and re-treat if it was not; and the evidence also before the Tribunal was that every week patients on the ward regularly had two boluses but went on to recover without any further interventions being necessary, so this was not an unusual occurrence. Accordingly, the Tribunal concluded that there was sufficient evidence available to Professor Thompson at the time to justify his decisions regarding the timings of the administration of both boluses.

73. Consequently, taking the evidence in the round, the Tribunal was satisfied that Professor Thompson not only appreciated the severity of Martha's physiological derangement, but also was entitled, on the information before him regarding the discrete issue of Martha's hypotension, not to undertake any more aggressive intervention than he did. On that basis, the Tribunal was satisfied that he did appropriately recognise and respond to Martha's hypotension. It considered that his decisions were made in accordance with NICE guidelines and that there was limited evidence that Professor Thompson failed to act upon relevant clinical information in respect of Martha's hypotension. He had been engaged, attended multi-disciplinary discussions and implemented a plan. The absence of a third bolus later in the evening appears to be linked to a failure to escalate new observations, not a failure on Professor Thompson's part to respond when properly informed.

74. The Tribunal therefore concluded that the GMC had failed to prove its case that Professor Thompson failed to appropriately recognise and respond to Martha's hypotension.

75. Therefore, on the balance of probabilities, the Tribunal found paragraph 1(a)(i) not proved.

Paragraph 1(a)(ii)

1. *On 29 August 2021, Professor Thompson failed to:*
    a. *…take more aggressive intervention from 12:00-13:00 in that he did not:*
        ii. *initiate further intravenous fluid resuscitation;*

76. Professor Thompson denied this allegation. His response to this allegation was as above.

77. The Tribunal repeats its observations as set out in its consideration of Paragraph 1(a)(i). On that basis, the Tribunal considered that the GMC had failed to prove its case that Professor Thompson failed to initiate further intravenous fluid resuscitation.

78. Therefore, on the balance of probabilities, the Tribunal found paragraph 1(a)(ii) not proved.

Paragraph 1(a)(iii)

1. *On 29 August 2021, Professor Thompson failed to:*
    a. *…take more aggressive intervention from 12:00-13:00 in that he did not:*
        iii. *escalate Patient A to the Paediatric Intensive Care Unit ('PICU') team for a direct clinical review;*

79. Professor Thompson denied this allegation. It was his evidence that on the evening of 29 August 2021, he spoke with Dr B who was the PICU Consultant on-call. They had discussed Martha's history, her current status and the possibility that she might deteriorate and require escalation to critical care. At the end of the call, he stated that they concluded that Martha could stay where she was but established that a bed in PICU was available should she need it. He also stated that, with the information he had at the time, escalating Martha to PICU was not warranted, although he accepted that, with hindsight, he should have.

80. The Tribunal notes Professor F's oral evidence, when he confirmed that sepsis was an adverse reaction to infection threatening the body and the purpose of a patient being referred to PICU would be to ensure that the patient survived in order to give time for antibiotics to take effect against the infection.

81. Medical records demonstrate that Martha's condition deteriorated over the course of the afternoon and early evening. Her blood pressure, initially at 105 mmHg at 14:00, dropped significantly to 84 mmHg at 18:00. Alongside this, her temperature rose sharply from 37.5° at

14:00 to 39.6° at 16:45 and remained elevated at 39.5° by 20:00. She also developed a new rash during this period (from around 13:00/13:30). Her lactate levels rose from 1.5 to 2.4 by 17:40. Her respiratory rate increased from 23 breaths per minute at 14:00 to 36 breaths per minute at 17:00 and at 17:45. Her heart rate also climbed from 106 to 126 bpm during roughly the same time window. Furthermore, her BPEWS rose from 4 at 10:00 to 8 at 17:00, such indicating further clinical decline. The Tribunal notes that Professor Thompson stated that BPEWS was an early warning score implemented by the Trust in 2021 which was used to help identify deteriorating patients. However, he qualified this by stating that BPEWS, as a standalone early warning score, had its limitations, being neither sufficiently sensitive nor specific. Having said that, a BPEWS of 8 was a level that required registrar review, which is what happened. In addition to these clinical figures, it was reported that this was the first day Martha required two fluid boluses - one at 11:00 and the second at about 17:00, which to the Tribunal suggested a new and atypical instability. The need for a repeated bolus within a single day should have heightened clinical concern.

82. In addition, the Tribunal notes that, in Martha's case, at around 17:00 there were one or more high risk indicators, as set out in the NICE Guidelines relating to sepsis. For example, a patient's respiratory rate is deemed to be a high risk indicator if it was 25 or over. At 17:00, Martha's was 36 and at 17:45 it remained at 36. Although it reduced to 25 at 19:00 it remained a high risk indicator. Moreover, it increased to 26 again at 20:00 hours. In addition, a blood pressure reading of 90 or less is also deemed to be a high risk indicator - Martha's blood pressure at 17:00 was 87 and at 18:00 was 84. Finally, a heart rate of 130 or more is also deemed to be a high risk indicator - Martha's heart rate at 16:45 was 131 although it reduced to 126 at 17:00. It remained so at 18:00 and was 122 at 2000.

83. In summary, by 17:00 or thereabouts there were several high risk indicators together with the re-emergence of a rash, Martha's increased temperature and a BPEWS score of 8. These changes collectively indicated a sudden and significant deterioration for no clearly identified reason. The situation was sufficiently concerning to Dr G for him to contact Professor Thompson to advise him, not only regarding the administration of a second bolus, but also about the new rash. Although Dr G and Professor Thompson agreed to involve the dermatological department regarding the rash, and notwithstanding that it appears that Professor Thompson was not made aware of the increased lactate level at 17:40, the Tribunal nonetheless considers that it was evident that by around 17:00, the clinical condition of Martha justified escalation to PICU and this opportunity was not taken.

84. Later that evening, at 20:30, Dr G again contacted Professor Thompson due to ongoing concerns regarding Martha's continued fever. Dr G anticipated the potential for PICU

involvement and was checking whether a bed would be available for Martha, asking Professor Thompson to speak with Dr B to confirm.

85. While some improvement in blood pressure was apparent at that time (20:30), it still remained at 93 which fell into the category of a moderate to high risk indicator under the NICE guidelines. Moreover, the respiratory rate remained a high risk indicator at 26. In addition, as indicated above, Professor Thompson was likely advised of the new lactate reading of 2.4 which was yet another new development. Finally, and perhaps most persuasively as far as the Tribunal is concerned, Martha's temperature had remained over 38° since 16:45 and was 39.5° at 20:00 hours. This was of such concern to Dr G, a very senior and experienced registrar, that he had specifically contacted Professor Thompson to discuss those concerns and to ensure that a bed was available in PICU should there be no improvement in her condition. The Tribunal notes that Professor Thompson expressed a preference to prearrange any PICU involvement rather than having PICU clinicians arrive unexpectedly and cause distress to Martha's parents. While the Tribunal understands the desire to manage the family anxiety sensitively, this did not, in its view, justify withholding or delaying a clinically indicated escalation of care. The Tribunal considered that, at the very least, this was the time that Professor Thompson should have escalated Martha to PICU.

86. In conclusion, therefore, given the clinical evidence of Martha's deteriorating condition at around 17:00 as described above, it was the Tribunal's view that a referral to PICU should have occurred at that time or shortly thereafter. If that opportunity was missed, escalation should have certainly taken place by 20:30 based on the continued moderate to high risk indicators, the new development of the lactate level increase and the absence of meaningful clinical improvement.

87. The Tribunal therefore concluded that the GMC has proved its case that Professor Thompson failed to take more aggressive intervention from 12 noon onwards in that he did not escalate Martha to the Paediatric Intensive Care Unit ('PICU') team for a direct clinical review.

88. Therefore, on the balance of probabilities, the Tribunal found paragraph 1(a)(iii) proved.

<u>Paragraph 1(a)(iv)</u>

1. *On 29 August 2021, Professor Thompson failed to:*
    a. *…take more aggressive intervention from 12:00-13:00 in that he did not:*
        iv. *in the alternative to a PICU referral, discuss Patient A with the*

*Microbiology Department regarding the overall antibiotic management of Patient A, including the administration of intravenous antifungal agents and/or the antimicrobial regime;*

89. Having found paragraph 1(a)(iii) of the allegation proved, in that Professor Thompson should have escalated Martha to the Paediatric Intensive Care Unit ('PICU') team for a direct clinical review, it therefore follows that paragraph 1(a)(iv) falls away.

90. Accordingly, the Tribunal found paragraph 1(a)(iv) not proved.

Paragraph 1(b)

1. *On 29 August 2021, Professor Thompson failed to:*
    b. *conduct a direct in-person review and assessment of Patient A, including Patient A's rash, which had developed that day from approximately 17:00 onwards;*

91. Professor Thompson denied this allegation. In his witness statement, he stated that *"I accept that I was falsely reassured by the reported improvements in [Martha]'s condition and I regret that I did not attend the hospital to review her in light of her subsequent deterioration. I was on call from home, but would have readily returned to the hospital if asked. When working from home in this way, I was dependent on the clinical skills and communication of my Registrar. In this case I was working with a very experienced Registrar, who indeed became a Consultant Paediatric* [XXX]*. If he had at any time suggested that he wanted me to see the patient, I would have returned to the hospital immediately. However, on this occasion, he did not request my attendance, and I had every reason to be confident in the information he was giving me. We discussed the rash and established that he had spoken with the on-call Dermatologist, who agreed to review the patient the following day."*

92. The Tribunal noted that by 17:00, all Martha's vital signs such as her tachycardia and her low blood pressure had deteriorated to the point where a second bolus was required. Additionally, there was a new and concerning development, namely the appearance of a new rash. As indicated above, the Tribunal is satisfied that at the time of his telephone conversation with Dr G at 17:00 hours, he would have been unaware of the elevated lactate level.

93. In his expert report, Professor F's made the following conclusions to the question as to whether Professor Thompson was adequately advised on Martha's septic rash. He opined that *"I would disagree with the terminology 'septic rash'; there is insufficient evidence to*

*determine that [Martha]'s rash on 29 August 2021 was solely due to sepsis. [Martha] developed an itchy, fine maculopapular rash on her abdomen on 23 August 2021. The medical records suggest that this rash faded within around 24 hours. [Martha] again developed an itchy, blanching maculopapular rash, over her trunk and upper legs from around midday on 29 August 2021. It is documented that there was a very small cluster of non-blanching petechiae on [Martha]'s left shoulder blade as part of the rash. It is not clear what the cause of [Martha]'s rash was; it may have been related to drug sensitivity and it may have been contributed to by sepsis (although I must add that the rash as described is not one routinely seen as a herald of severe sepsis). I do not however consider that the emergence and development of the rash, by itself, should have led to a sudden reorientation of [Martha]'s care."*

94. However it was Professor F's opinion that *"Given that Professor Thompson did not understand the aetiology of [Martha]'s rash, and with it developing in the context of new physiological derangements (particularly low blood pressure requiring intravenous fluid resuscitation), it is my opinion that he should have made a direct assessment of [Martha] and her rash following its onset."*

95. Whilst the Tribunal understands that Professor Thompson may have had confidence in Dr G due to his experience and seniority, it was nonetheless expected that Professor Thompson would rely on his own clinical judgement. It acknowledged that, after his discussion with Dr G, a decision was made to refer Martha to the dermatology team the following day. However, Professor Thompson's own observations on Martha's overall condition, including that of her rash, may have provided more immediate insight, rather than relying solely on Dr G's assessment. The Tribunal also notes, from its collective experience, that doctors often obtain more useful and accurate information about a patient's condition through direct observation, rather than depending solely on clinical readings - indeed, Professor F alluded to this in his evidence and indicated that the presentation of the patient when assessing whether sepsis was present, "*could be really useful*".

96. Given that the Tribunal has already found that Professor Thompson should have escalated Martha to PICU at 17:00 or, if not then, at 20:30 following the second administered bolus, Martha's continued deterioration and the new information regarding her lactate level. It considered that a direct in-person review and assessment of Martha, including her rash, would have, more likely than not, been beneficial. Indeed, the Tribunal considers (as it did in respect of its decision under paragraph 1(a)(iii)) that if Professor Thompson had not have conducted a direct in person review of Martha at 17:00, then he should have done so at 20:30, especially since he was then advised of the new development concerning the lactate level and the continuing fever being suffered by Martha.

97. The Tribunal therefore considered that the GMC has proved its case that Professor Thompson failed to conduct a direct in-person review and assessment of Martha, including her rash, from approximately 17:00 onwards.

98. Therefore, on the balance of probabilities, the Tribunal found paragraph 1(b) proved.

99. The Tribunal pauses there to make the following observations. If Professor Thompson had come in to the hospital to conduct a direct in-person review and assessment of Martha at 17:00, he would no doubt have discovered that no observations had been taken in respect of Martha from 14:00 to at least 16:45 (The Tribunal has received no evidence that this lacuna was observed by Dr G or that he communicated such to Professor Thompson). The Tribunal notes that one of the advantages of escalating a patient to PICU would have been an increased level of monitoring. Although no explanation has been given to the Tribunal for the failure to monitor Martha between 14:00 and 16:45, this absence of monitoring on the ward would no doubt have been a significant factor in justifying such an escalation. Furthermore, if Professor Thompson had attended the hospital in person following his telephone conversation with Dr G at 20:30, he would have been made aware of the significant deterioration in her blood pressure from its level of 93 as at 20:00. The Tribunal reminds itself that Martha's blood pressure fell to 85/46 at 20:45 and was 90/42 at 21:00 hours. This in turn would have justified a third bolus being administered which in itself would, pursuant to the agreement between Professor Thompson and Dr G, have automatically resulted in a referral to PICU. Whilst both of these factors were not known to Professor Thompson at the times that he made his respective decisions not to return to the hospital shortly after 17:00 or 20:30, they nonetheless emphasise some of the advantages of conducting direct in-person reviews and assessments of patients.

<u>Paragraph 1(c)(i)(1)</u>

1. *On 29 August 2021, Professor Thompson failed to:*
    - *c. adequately communicate with Dr B in the PICU team during his call at 21:41 in that he:*
        - *i. provided Dr B with an incorrect:*
            1. *systolic blood pressure reading of 100mmHg given that Patient A's systolic blood pressure had been below 100mmHg since 14:00;*
            2. *serum lactate reading of 1.5mmol/l which was taken at 13:39 when Patient A's most recent serum lactate reading taken at 17:40 was 2.4 mmol/l;*

100. Professor Thompson denied this allegation. He accepted that these blood pressure and lactate figures were incorrect. However, his evidence was that he did not make a record of the blood pressure or lactate values provided to Dr B on the telephone. In his oral evidence, Professor Thompson accepted that when Dr G telephoned him at around 17.00, it was to discuss Martha's hypotension and the need for her to have a second bolus and that would have meant Martha having blood pressure readings of below 100. He accepted that Dr G would, in those circumstances, have given him the correct readings and, in his words, he had no reason to think otherwise. It was Professor Thompson's evidence was that he had no reason to give Dr B out of date values and he felt sure that he gave Dr B the most recent values that he had been given by Dr G.

101. The Tribunal considered the available evidence to this allegation. It noted that the source of the allegation was Dr B's oral evidence at the Coroner's Inquest, dated 25 February 2022, *"I was told that the lactate was 1.5, the blood pressure 100"*.

102. The Tribunal considered the evidence of the telephone call between Professor Thompson and Dr B at 21:41. It is accepted that they discussed Martha, as well as two other patients. The earliest record of this telephone call was a clinical note dated 30 August 2021, made retrospectively less than 24 hours after the telephone conversation between Professor Thompson and Dr B:

> *"Doctor's note: I was contacted last night 29/9/2021 21:41 by Prof Richard Thompson to discuss 3 patients - the third patient discussed was Martha Mills. I was told that she is a 13 year old girl with handle bar injury 4-5 weeks back, has suspected PIC line infection, the team is using the line only for antibiotics, has got a rash after Tazocin given a few days back, they are suspecting Dresslers and Dermatology team will review her for skin biopsy, HLH was worked up for, she is stable now , had received 10+ 10 mls/kg fluid in the day, on enquiry, lactate was < 2 with positive base excess. I was told that this was just to let us know about the patient in case she deteriorated in the night but the patient is not meant for review now by PICU team as she is stable at the moment and if required the ward team will contact the PICU team. I confirmed that we have HDU/PICU bed and will be very happy to review whenever we are called. I got called at 08:04 on 30/08/2021 by PICU registrar* [Dr K] *that she was asked to review Martha just now on the ROS ward who apparently developed vaso-vagal episode, is hypotensive and tachycardic, her sodium was 123 - I asked her to give fluids, give 3 mls per kg of 3% saline and confirmed that liver consultant is informed., I was told he is on his way. By this time, it was 08:17 I handed over to the incoming PICU Consultant* [Dr J] *who immediately attended to the patient as she was already there in the*

*hospital.*
*-Entered on 31-Aug-2021."*

103. The Tribunal bore in mind that there was no mention of any blood pressure readings within the clinical note and the lactate reading was given as *"<2"*. In particular, the Tribunal noted that there were also further opportunities for Dr B to state what readings for Martha's blood pressure and lactate levels he was given by Professor Thompson. In his written statement given on 15 September 2021, Dr B referred to the lactate and blood pressure figures as being "*normal*" but gave no specific figures. He was interviewed on 4 November 2021 with relation to the SUI inquiry and gave the same evidence, without indicating what the figures were. In his written statement to the inquest dated 10 January 2022, he again referred to Martha being "*stable*" with normal lactate and blood pressure readings, but again not indicating what exactly those readings were. Consequently, the Tribunal took into account that on four occasions prior to him giving oral evidence at the inquest on 22 February 2022, Dr B merely referred to the blood pressure and lactate figures in general unspecified terms (the only exemption being in his clinical note on 30 August 2021 when he referred to the lactate level as "*below 2*"). Dr B was unable to say why he was suddenly able to recall these specific readings.

104. The Tribunal also took into account that at no stage on 29 August 2021 was Martha's blood pressure reading at exactly 100. Medical records show that her blood pressure was 102 at one point but it was otherwise mostly in the mid to late 90s. The Tribunal considered it likely that in his last telephone call with Dr G at 20:30, Professor Thompson would have been given the most up to date figures which were, for blood pressure, at that time consistently below 100, and were 2.4 for the lactate figure.

105. The Tribunal was cognisant that the first and only mention of specific figures of Martha's blood pressure and lactate readings was Dr B's oral evidence at the Coroner's Inquest, which was six months after the event. Whilst it was not suggested that Dr B made up the figures, in the absence of any reliable and consistent evidence, the Tribunal cannot speculate about where these figures came from.

106. In his closing submissions on facts, Mr Rich invited the Tribunal to take into account the distorting effects of the pressure that was on clinicians in this case, including Dr B, which would already have been present even when he wrote the retrospective clinical note. Mr Rich reminded the Tribunal of the prominence and emotional impact of this case and submitted that it was hard to imagine a situation more likely to distort the memories of those involved. The Tribunal accepted that there was a possibility that Dr B might have unconsciously come up with the precise figure of 100, six months later at the Coroner's

Inquest, or had unconsciously assimilated the lactate reading of 1.5 during the mortality meeting he had attended on 30 September 2021 but, notwithstanding Mr Rich's suggestion, the Tribunal nonetheless considered that Dr B's evidence on this allegation was so unreliable that it was insufficient to prove it.

107. Furthermore, the Tribunal considered it improbable that Professor Thompson would make up misleading figures and then provide an incorrect figure later to Dr B in the telephone call. The Tribunal considered it more likely that Professor Thompson knew that the blood pressure figures were in the 90s and the lactate figure was 2.4 and that the specific figures of 100 or 1.5 were not given.

108. The Tribunal considered there was limited evidence on this matter. The evidence to support this allegation effectively rested on the sole reference from Dr B's account of events at the Coroner's Inquest and the Tribunal concluded that, given its significant inconsistency, this evidence was unreliable.

109. The Tribunal therefore concluded that the GMC has failed to prove its case that the specific figures as above were given.

110. Therefore, on the balance of probabilities, the Tribunal found paragraph 1(c)(i)(1)&(2) not proved.

Paragraph 1(c)(ii)

1. *On 29 August 2021, Professor Thompson failed to:*
    c. *adequately communicate with Dr B in the PICU team during your call at 21:41 in that he:*
        ii. *did not include Patient A's rash which had developed that day, in his discussions with Dr B.*

111. Martha developed a rash due to an allergic reaction after taking Tazocin on 25 August 2021. She then switched medication, and the rash disappeared prior to 29 August 2021. Martha then developed a new rash on 29 August 2021. Medical notes recorded stated that the new rash *"developed today across the trunk and upper legs..."* and a "*couple of hours later widespread across chest abdomen back and shoulders, assessed by SHO and REG aware late reaction/syndrome to TAZ refer to drs note as liaised with dermatology to have skin biopsy tomorrow".*

112. It was accepted that during the telephone call between them, there was clearly a discussion between Professor Thompson and Dr B of *a* rash. However, it was in dispute whether discussions of 'a rash' concerned the rash that Martha had previously had which disappeared the previous week or the new rash that had developed on 29 August 2021. It was the GMC's case that Professor Thompson did not adequately communicate with Dr B in that he did not discuss Martha's new rash which had developed that day.

113. Professor Thompson denied this allegation. It was his evidence that during the telephone call with DrB, he had discussed the rash and Dr B had acknowledged that an arrangement had been made for the Dermatologist to review Martha the following day. He stated that this was evidently not the rash that developed several days earlier, but the new manifestation, which Dr G had discussed on 29 August 2021 with the Dermatologists, and that they had agreed to see Martha the next day.

114. Professor Thompson had two telephone calls during the evening of 29 August 2021 with Dr G about Martha's condition. During their first call around 17:00, Dr G and Professor Thompson did not know what the new rash was and considered it may have been a recurrence of the allergy rash induced by Tazocin medication. It was his evidence that because of the rash and increased eosinophils Dr G suggested a potential diagnosis of Drug Reaction with Eosinophilia and Systemic Symptoms ('DRESS') syndrome, which Professor Thompson did not think was particularly likely, although he said he kept an open mind. They then agreed that Martha's new rash warranted a discussion with the Dermatology department. Following the second call with Dr G discussing Martha, they agreed that he should contact the on-call Consultant Intensivist who was Dr B.

115. In the retrospective clinical note dated 30 August 2021, following the telephone call, Dr B documented that the dermatology team would be assessing the patient's rash. He recorded *"[Martha] has got a rash after Tazocin given a few days back, they are suspecting Dresslers [sic] and Dermatology team will review her for skin biopsy".* Based on this evidence, the Tribunal was satisfied that Dr B was aware that the dermatology team has been consulted, confirming that a rash had indeed been discussed and it possibly was attributed to a recent course of Tazocin medication. It also noted that Dr B had recorded Professor Thompson's opinion of the cause, the differential diagnosis and the proposed management. The Tribunal reasonably inferred that the dermatology referral could only have been prompted by the onset of the new rash and therefore that Dr B was aware of this context. It was therefore satisfied that Professor Thompson had adequately communicated with Dr B, including information about the rash that had developed that day.

116. Accordingly, the Tribunal considered that the GMC had failed to prove its case that Professor Thompson failed to include Martha's rash which had developed that day, in his discussions with Dr B.

117. Therefore, on the balance of probabilities, the Tribunal found paragraph 1(c)(ii) not proved.

## The Tribunal's Overall Determination on the Facts

118. The Tribunal has determined the facts as follows:

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

1. On 29 August 2021, you failed to:
    a. appreciate the severity of Patient A's physiological derangement and take more aggressive intervention from 12:00-13:00 in that you did not:
        i. appropriately recognise and respond to Patient A's hypotension;
        **Not proved**
        ii. initiate further intravenous fluid resuscitation;
        **Not proved**
        iii. escalate Patient A to the Paediatric Intensive Care Unit ('PICU') team for a direct clinical review;
        **Determined and found proved**
        iv. in the alternative to a PICU referral, discuss Patient A with the Microbiology Department regarding the overall antibiotic management of Patient A, including the administration of intravenous antifungal agents and/or the antimicrobial regime;
        **Not proved**
    b. conduct a direct in-person review and assessment of Patient A, including Patient A's rash, which had developed that day, from approximately 17:00 onwards; **Amended under Rule 17(6)**
    **Determined and found proved**
    c. adequately communicate with Dr B in the PICU team during your call at 21:41 in that you:
        i. provided Dr B with an incorrect:
            1. systolic blood pressure reading of 100mmHg given that Patient A's systolic blood pressure had been below 100mmHg since

14:00;
Not proved

2. serum lactate reading of 1.5mmol/l which was taken at 13:39 when Patient A's most recent serum lactate reading taken at 17:40 was 2.4 mmol/l;
Not proved

ii. did not include Patient A's rash, which had developed that day, in your discussions with Dr B. Amended under Rule 17(6)
Not 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 - 09/06/2025

119. 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, Professor Thompson's fitness to practise is impaired by reason of misconduct.

The Evidence

120. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary.

121. Within Professor Thompson's witness statement dated 8 April 2025 that the Tribunal was provided with at the Facts stage, he provided details of his current work in that he splits his time equally between academic and clinical work. Professor Thompson stated that his academic work was focused on research relating to the genetics of liver disease and understanding the pathophysiology of such diseases. He stated that his clinical work related solely to reviewing patients in the paediatric liver day-case unit and laboratory-based diagnostic services for liver, gastrointestinal and pancreatic disease. Professor Thompson stated that he was the clinical lead for the laboratory which provides diagnostic services for approximately 70% of the country, and also that he provides specialist advice and support to colleagues around the country. He stated that his decision to no longer provide in patient care was made as a result of this case, which had a profound impact on him. Professor Thompson stated that he was deeply sorry for the pain these events had caused Martha's family and friends. He stated that he wanted to express his sincere condolences once again

for their loss. Professor Thompson stated that, following Martha's tragic death, he had completed CPD training relating to the management of sepsis and the deteriorating child in paediatric care. He stated that he also continually reflects more widely on his practices and improvement that he could make within his changed role.

122. In addition, the Tribunal received further evidence as follows:

123. On behalf of the GMC, the Tribunal was provided with a statement dated 24 March 2025 from Dr L, Professor Thompson's Responsible Officer. Dr L stated that he understood that Professor Thompson fully cooperated with the Trust Serious Incident investigation surrounding Martha's death and an external review. Dr L stated that, after Martha's death, Professor Thompson voluntarily stopped undertaking the element of his job that involved the care of acutely ill patients and now only undertakes outpatient care. Dr L stated that most of Professor Thompson's time is spent running the diagnostic and genetics service for liver/gastrointestinal/pancreas genetics that covers 70% of all paediatric and adult activity in England. Dr L also stated that Professor Thompson had told him that he had apologised on more than one occasion to Martha's parents for her death. Dr L stated that Professor Thompson feels deep remorse for Martha's death but does not feel that he made any errors in her care.

124. Additional documents were provided to the Tribunal on behalf of Professor Thompson. These consisted of positive testimonials from eight colleagues, a Continuing Professional Development (CPD) activity report, and details of training undertaken in respect of sepsis. The activity report provided details of Professor Thompson's CPD from August 2020 to May 2025, which includes details of training and attendance at various conferences and clinical meetings. Professor Thompson completed e-learning courses on sepsis in paediatrics on 13 May 2023 and sepsis in adults on 8 March 2025. He attended various talks about sepsis on World Sepsis Day at the Trust on 13 September 2024.

125. Included in the testimonials was a letter from Professor M, Consultant Hepatologist & Professor of Hepatology, who stated that he had worked with Professor Thompson from 1997, and then as a consultant colleague from 2003. Professor M stated that Professor Thompson's *"standard of clinical practice has always been excellent"* and has been a 'go to' colleague for many *"particularly when it came to looking after children growing into adulthood with unusual biliary or cholestatic disorders that we would never have seen before"*. Professor M stated that Professor Thompson's commitment and participation in CPD had been exceptional. He referred to the European Association for the study of liver annual

meeting in Amsterdam where Professor Thompson delivered the state-of-the-art lecture at the postgraduate course of this meeting attended by over 7500 adult and paediatric liver practitioners from around the world. Professor M stated that Professor Thompson had agonised about his participation in the care of this case and, by his nature, he is highly self-critical and reflective. He stated that any adverse findings against Professor Thompson would have a *"significant impact on the evolution of liver medicine and the interaction between genetic liver disease and novel therapies".*

126. Another of the testimonials was written by Dr N, a senior clinical lecturer of paediatric hepatology, on 20 September 2024. Dr N stated that they had known Professor Thompson as a colleague since 2009. Dr N stated that they always felt safe and well supported by Professor Thompson when working as a specialist registrar, that he was very thorough with the patients and felt comfortable to ring him at any time about anything they were worried about. Dr N stated that, as a registrar and now as a consultant, their opinion of Professor Thompson was that he is a very knowledgeable paediatric hepatologist, who is world renowned for his expertise. Dr N stated that they had always had an excellent collegiate relationship with Professor Thompson and seen him as a very caring doctor towards his patients and their families.

## Submissions

Submissions on behalf of the GMC

127. Mr Rose, Counsel, submitted that the correct finding in this case is that the proven allegations amount to misconduct and that Professor Thompson's fitness to practise remains impaired.

128. Mr Rose submitted that the following paragraphs of Good Medical Practice (2013) ('GMP') were engaged in this case:

*"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.*

*2 Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients*

*receive good care and treatment that will support them to live as well as possible, whatever their illness or disability.*

*7 You must be competent in all aspects of your work, including management, research and teaching.*

*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.*

*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:*

*… b provide effective treatments based on the best available evidence…*

*18 You must make good use of the resources available to you."*

129. Mr Rose stated that Professor F had provided both written and oral evidence that the failures found proved amount to serious failures, i.e. that they were seriously below the required standard expected of a Consultant Paediatrician in Professor Thompson's position. Mr Rose submitted that this was clear evidence that the failures had reached the standard needed to amount to misconduct.

130. Mr Rose referred to the Tribunal's findings on the Facts. He stated that the findings included that, at the point when Martha was seriously deteriorating, Professor Thompson neither personally reviewed Martha nor sought a review from PICU. Mr Rose stated that it was probable that either action would have resulted in Martha's admission into PICU.

131. Mr Rose submitted that the proven failures amount to misconduct for a number of reasons. Martha was a paediatric patient with a significant underlying injury who had been exhibiting signs of infection for the preceding week. Mr Rose submitted that this made Martha particularly vulnerable not simply to sepsis but to a sudden significant deterioration as a result of sepsis. He stated that Martha therefore required particularly careful management. Mr Rose stated that Professor Thompson was the duty Consultant responsible

for Martha on that day. Mr Rose stated that Professor Thompson was already familiar with Martha's case prior to that day and, by 17:00, was fully aware of her worsening situation through his direct involvement in the morning and from the information that was passed to him by Dr G.

132. Mr Rose stated that, on the Tribunal's findings, the indications that Martha was deteriorating further and was on a trajectory to becoming gravely ill, were obvious and should have been apparent to Professor Thompson. By 17:00 Martha had returned to being hypotensive, her heart rate and respiratory rate remained raised, she had temperature spikes and a new rash. Mr Rose maintained that, by 20:30, Professor Thompson was aware that all of those indicators were persisting and her serum lactate reading was worsening. Mr Rose submitted that the steps that Professor Thompson should have taken were obvious and easily achievable, i.e. that he undertake an in-person review and escalate her for a direct review by the PICU team. Mr Rose submitted that Professor Thompson's failings were fundamental ones and clear breaches of GMP. He stated that, if Professor Thompson had taken those steps, they would have - on balance - led to Martha's admittance into PICU where she would have received a level of monitoring and intervention that her condition required at that point. Mr Rose referred again to Professor F's evidence that the failings amount to serious departures from the required standard. Mr Rose submitted that such a serious departure was capable of amounting to misconduct.

133. In terms of impairment, Mr Rose stated that Professor Thompson was and remains a highly regarded and respected clinician. He stated that, when dealing with clinical failings that have been found to be sufficiently serious so as to amount to misconduct, the fact that Professor Thompson was so highly regarded, as a Consultant of many years' experience, meant that his failings in respect of his care of Martha were particularly inexplicable.

134. Mr Rose stated that Professor Thompson's account was that, at the time, based on what he knew, he believed that he was making the right decisions about Martha's care, including that she did not require a referral to the PICU team and he did not need to come into the hospital to review her directly. Mr Rose stated that there was no evidence of any factors, external or otherwise, that would explain why Professor Thompson wrongly believed that he was making the right decisions in respect of those two matters. Mr Rose submitted that, in the absence of such evidence, what remained is that a senior and experienced Consultant, highly respected by his peers, who had the support of a team including a senior specialist registrar, and had all the necessary information required to make the right decisions, fell seriously below the required standard. Mr Rose submitted that it followed that

a finding that Professor Thompson's fitness to practise was impaired at the time was a logical and inevitable conclusion to reach.

135. Mr Rose stated that the next step to consider was whether Professor Thompson's fitness to practise currently remains impaired. He stated that it was important to remember that the consideration is whether Professor Thompson is fit to practise without restriction in any clinical role that he could reasonably undertake as a Consultant Hepatologist (i.e. should he return to his old role of caring for acutely ill paediatric patients at some stage in the future). Mr Rose stated that the consideration was not restricted to whether Professor Thompson is fit to practise in his current role which he has voluntarily restricted, on his evidence as a result of the impact which these events had on him.

136. Mr Rose submitted that the fact that Professor Thompson had voluntarily practised in a restricted role since these events occurred means that the Tribunal has limited practical evidence upon which to assess whether Professor Thompson has remediated. Mr Rose stated that Professor Thompson considered that he was not safe to continue practising in his existing role, either because of the effect of the index events on XXX or because he had become excessively cautious or doubted his own judgement. Mr Rose stated that Professor Thompson's role has subsequently involved dealing with outpatient referrals and undertaking academic research; he has not treated acutely unwell paediatric patients. Mr Rose submitted that, whilst there was no evidence of any subsequent concerns arsing, there had been no opportunity to assess Professor Thompson's performance in the sort of situation which gave rise to the misconduct.

137. Mr Rose referred to the training undertaken by Professor Thompson, including courses on sepsis as detailed above. Mr Rose stated that Professor Thompson's evidence was that he did not gain any new knowledge or understanding of the management of sepsis and that, instead, it reinforced his existing knowledge. Mr Rose submitted that there was little evidence that, from the participation in the three one day courses, Professor Thompson has significantly remediated.

138. With regard to insight, Mr Rose stated that Professor Thompson had clearly extensively reflected about his care of Martha and the question of whether or not he made mistakes. Mr Rose stated that Professor Thompson has previously accepted that Martha should have been referred to the PICU team around about 17:00. Mr Rose stated that, by the point of this hearing, Professor Thompson had concluded that he was right not to have referred Martha. Mr Rose submitted that Professor Thompson has never considered that, on

the information available to him at the time, he should have come into the hospital to review her, albeit that knowing now what the outcome for Martha was, he wishes he had done so.

139. Mr Rose stated that, notwithstanding the obvious impact that these events have had on Professor Thompson, he remains of the opinion that he did nothing wrong - as evidenced by the statement from his Responsible Officer. Mr Rose submitted that it followed therefore that there was no evidence upon which the Tribunal can conclude that Professor Thompson has developed sufficient insight into the causes of his failures in the care of Martha.

140. During Mr Rose's submissions, he was asked a number of questions by the Tribunal. Mr Rose stated that Professor Thompson's actions were not a single incident in the sense of a single act. Mr Rose stated that there were two failings and submitted that they were both significant due to the extent of Martha's illness, the risk she was at, and the obvious nature of what was happening to her. Mr Rose submitted that it would be wrong to describe Professor Thompson's actions as a single incident as it was an evolving process during the course of an afternoon where there were three opportunities (two telephone calls with Dr G and one discussion with Dr B) where the decision to refer Martha to PICU could have been made but erroneously was not. Mr Rose stated that, certainly around 17:00, a decision by Professor Thompson to review Martha himself could have been made which would have no doubt led to a referral to PICU.

141. Mr Rose was also asked how, if at all, Martha's death fitted into the equation. Mr Rose replied that it did not. Mr Rose stated that there had been serious failings but, regardless of Martha's outcome, this did not lessen or undermine the nature of the failing. Mr Rose reminded the Tribunal that Professor F considered that, even if there had been a referral to PICU, in his opinion and on balance Martha would still have died. However, Professor F could not exclude the possibility that Martha would have survived if she had been admitted to PICU and that, on balance, it would have given Martha the added chance to survive. Mr Rose stated that the point was that, if the steps found proved were required, then they were required regardless of the outcome. Mr Rose submitted that it was perhaps the risk of death that was relevant to the Tribunal's considerations rather than the death itself. He submitted that Martha was a paediatric patient who was very unwell such that the need to provide the highest level of care and careful management, including escalation to the PICU team and to have a direct review around 17:00, were particularly important.

Submissions on behalf of Professor Thompson

142. Mr Rich, Counsel, submitted that the Tribunal should not making a finding that Professor Thompson's actions amount to misconduct or that his fitness to practise is currently impaired.

143. Mr Rich stated that the Tribunal's findings related to clinical judgements made about a single patient, Martha, over a period of some four to five hours on 29 August 2021. Mr Rich stated that Professor Thompson acknowledges that the facts found proved represent significant clinical issues.

144. Mr Rich stated that Professor Thompson has been a dedicated doctor and specialist for nearly forty years and has never before been investigated by his regulator. Mr Rich stated that Professor Thompson has a reputation as a hard-working and outstanding clinician and researcher, who has an international reputation as one of the leading paediatric liver specialists in the world.

145. Mr Rich stated that it has never been the GMC's case that Professor Thompson's decisions were made in bad faith or without having Martha's best interests in the foreground. Mr Rich submitted that the heart of this case is that Professor Thompson underestimated Martha's deterioration on this occasion. Mr Rich reiterated that it was Professor F's conclusion that, even if Professor Thompson had initiated the reviews, it would sadly not have saved Martha.

146. Mr Rich submitted that it was notable that the other medical staff involved in Martha's care that day, especially Dr G the ST8 registrar, did not raise concerns that her condition was being underestimated. Mr Rich stated that Martha had very complex medical issues and, whilst they were all concerned for her, they did not anticipate her sudden and catastrophic collapse on the morning of 30 August 2021. Mr Rich stated that it was not a case where the doctor was refusing to engage with a patient and, accepting Professor Thompson was the most senior person dealing with the case on that day and so bears the responsibility, submitted that it was significant that it was not a case where everyone could see the issues apart from him.

147. Mr Rich stated that Martha's death has had a profound effect on Professor Thompson, such that he has given up his in-patient on call role altogether as he found himself

lacking in confidence and practising in what he considered to be a sub-optimal and excessively defensive way.

148. In terms of misconduct, Mr Rich submitted that Professor Thompson's actions, while involving a number of judgements across the four to five hours, had the characteristics of a single incident. He stated that, if that was correct, the Tribunal would have to conclude that Professor Thompson's failings were *"particularly grave"* in order to find that it was misconduct. Mr Rich submitted that the Tribunal should not make that finding as the judgements made were difficult, nuanced and evaluative judgements about exactly when reviews might be needed. He stated that Professor Thompson's assessment of Martha's condition was done in good faith and Professor Thompson did escalate the case to Critical Care for what has been called an *"informal review"* albeit that it is accepted that the Tribunal has found a direct review should have been called for. Mr Rich stated that Martha had an exceptionally complex presentation which had fluctuated over the previous weeks. He submitted that Martha's deterioration was recognised but that the Tribunal has found that it was underestimated that evening in that Professor Thompson should have appreciated that she needed an in-person review by him. Mr Rich submitted that there was no evidence of any general reluctance on Professor Thompson's part to come to the hospital when on call.

149. Mr Rich submitted that, while the Tribunal has found there was a serious failing in not initiating the two reviews, by the standards of medical misjudgement it should not be characterised as *"particularly"* grave because Professor Thompson had been managing the case in an appropriate and effective way up to the evening and had put a plan in place. The plan was that if Martha's blood pressure dropped again there would have been a direct Critical Care review. In the event, Martha's blood pressure dropped suddenly at 20:45 to 85/46 from 93/52, but not only was a third bolus not given, but there was no referral to PICU. Mr Rich stated that the Tribunal has found that it was not Professor Thompson's fault that this plan appears not to have been followed. Mr Rich also stated that Professor Thompson did initiate a dialogue with Critical Care and that, whilst the Tribunal's findings include that - effectively - Professor Thompson relied too much on Dr G's observations in the evening hours, in general terms Dr G was of a seniority that meant relying on him was reasonable. Further, Mr Rich submitted that the extent to which seriously sick patients were nursed on the ward at the time mitigates the error found regarding the judgement over when the patient should be admitted to PICU.

150. Mr Rich stated that an equivalence is sometimes suggested between a finding that an action or omission (as in this case) is 'seriously below' the standard expected and a finding

that the omission amounts to misconduct. He stated that the Tribunal had received evidence from Professor F that his opinion was that each of these omissions was 'seriously below' the required standard. Mr Rich stated that, while it was accepted that the findings amount to a falling short of the standards required, it was submitted that the Tribunal should not accept Professor F's opinion that they are 'seriously below'. Mr Rich reminded the Tribunal that Professor F wrote his report entirely without reference to the NICE guidelines and they only became prominent when Professor Thompson mentioned them in passing in his oral evidence. Mr Rich submitted that their omission from Professor F's report was surprising and undermined his credibility. Further, Mr Rich stated that the Tribunal had, partly on the basis of the NICE guidelines, rejected Professor F's opinions on some matters which he suggested were 'seriously below', in particular Professor Thompson's alleged failure to appreciate the severity of Martha's physiological derangement and his alleged failure to initiate further intravenous resuscitation.

151. Mr Rich stated that it was, of course, open to the Tribunal to accept Professor F's opinions on some issues and not others but that the degree of failure represents a judgement call and Professor F's judgements have proved to be flawed. Mr Rich submitted that the Tribunal does not have sufficient reliable evidence to draw the conclusion on the basis of Professor F's opinion that the two omissions found were 'seriously below'. Mr Rich stated that the Tribunal therefore has to arrive at a judgement of its own. He submitted that, in this context, the consideration of whether the omissions were *"particularly grave"* is a better basis for a decision than whether they were 'seriously below' or merely 'below' the required standard. Mr Rich submitted that this decision should be based on all of the factors he has set out, including how difficult these calls were and are in cases like Martha's. Mr Rich submitted that, taken in its context, the clinical errors identified should not be stigmatised as *"particularly grave"* or would not be regarded as *"deplorable"* by other members of the profession and so do not merit a finding of misconduct.

152. Mr Rich went on to submit that Professor Thompson's fitness to practise is not currently impaired. He submitted that Professor Thompson is currently no risk to any patients. Mr Rich stated that this was based, not on the fact that Professor Thompson does not do in-patient and acute work anymore, but on the evidence that - even if he started to do that sort of work again - he would never repeat the omissions found in this case. Mr Rich addressed the suggestion from the GMC that Professor Thompson voluntarily practising in a restricted role meant there was limited evidence upon which to assess remediation. Mr Rich stated that the evidence was firmly on the side of Professor Thompson practising safely in response to his assessment that he was not practising in an efficient manner.

153. Mr Rich submitted that Professor Thompson's actions were a single lapse (omitting to initiate two reviews at the same time on one patient) in a very lengthy and distinguished career. Mr Rich stated that Professor Thompson had made fundamental changes to the way that he practised in the acute setting before he stepped back from such work in 2022. Mr Rich maintained that Professor Thompson has full insight into the issues raised by this case and had internalised the views of others about those issues, even where he does not entirely agree with them. Mr Rich stated that Professor Thompson does not pose a risk to patients and, if there was any risk, it would be that he would be too cautious and defensive. Mr Rich stated that Professor Thompson has continued to complete relevant CPD and has comprehensively addressed the specific issues of this case. Mr Rich stated that Professor Thompson's references testify to his reputation for careful practice with great attention to detail. He stated that Professor Thompson's care for patients was viewed by his colleagues as exemplary. Mr Rich also stated that Professor Thompson's technical ability, even with the most complex patients, was not questioned before Martha's very sad case and has not been questioned again since; there has been no repetition in the following four years.

154. With regard to remediation, Mr Rich stated that Professor Thompson has made targeted efforts to rehabilitate himself and referred to the CPD material provided.

155. Mr Rich stated that, while Professor Thompson denied the two allegations found proved, it is submitted he has shown full insight into the complex clinical issues raised by this case. The Tribunal is reminded that *"[a]bsence of insight - if it means no more than that [the doctor's] evidence… was not accepted … is an inappropriate use of the concept as a basis for a finding of impairment"* [*Vali v General Optical Council* [2011] EWHC 310 (Admin)].

156. Mr Rich submitted that Professor Thompson has reflected self-critically on his performance on that day and, while not accepting his conclusions on the omission to trigger the reviews, the Tribunal has found in his favour on many issues. Mr Rich stated that Professor Thompson has undertaken relevant sepsis CPD and his views have gone back and forth regarding what would have been the right thing to do. Mr Rich stated that Professor Thompson has not displayed any stubborn refusal to accept that he might have made a mistake in his treatment of Martha and has changed the whole way he dealt with deteriorating patients. Further, Mr Rich stated that Professor Thompson's personal struggle with the sad outcome of the case was clear evidence of insight and the testimonials also gave reassuring accounts of the insight he has shown.

157. Mr Rich submitted that, given the remediation and insight shown, there was effectively no risk that Professor Thompson would make a similar mistake, nor was there any evidence to suggest his judgement might be more generally flawed in some other clinical area.

158. In terms of public confidence, Mr Rich stated that the Tribunal understands that it must set aside the high public prominence of the case and consider what a sober, thoughtful and fair person would make of what happened. Mr Rich submitted that the Tribunal should remind itself that such a member of the public would be aware of all of the matters which put the mistakes found by the Tribunal into context, and testify to the seriousness with which Professor Thompson has analysed and reacted to the incident. Mr Rich submitted that a fair-minded member of the public would see an outstanding clinician who had, for a few hours, misjudged to an extent the seriousness of the decline of one patient, Martha, but who has otherwise been a safe clinician in a very long career. Mr Rich submitted that they would also appreciate that any misjudgement did not arise from morally culpable incompetence or laziness, but from the sort of error which no professional can be sure they will never commit. He stated that they would also note the testimonials that act as reassurance that Professor Thompson is a very talented and safe clinician, and the devastating effect of the internal and external inquiries, the inquest, and these proceedings have had on Professor Thompson. Mr Rich submitted that confidence in the profession could be maintained simply by the finding of misconduct and did not require a further finding of current impairment.

## The Relevant Legal Principles

159. 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.

160. 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 that the misconduct was serious), and then whether the finding of that misconduct (which was serious) could lead to a finding of impairment.

161. The LQC referred to the case of *Roylance v GMC* [2000] 1 AC 311, in that 'misconduct' has been defined as:

*"…a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances."*

162. Moreover, the misconduct must involve Professor Thompson falling not just short, but far short, by omission or commission, of the standards of conduct expected of a Consultant Paediatric Hepatologist. The LQC stated that such falling short as is established must be serious (*Roylance* and *Cheatle v GMC* [2009] EWHC 645 (Admin)). He advised that seriousness must be given its proper weight and has been referred to in other contexts as *"conduct which would be regarded as deplorable by fellow practitioners"* (*Nandi v GMC* [2004] EWHC 2317 (Admin)). The LQC stated that *"deplorable"* can be defined as *"deserving strong condemnation"*; the synonyms listed in an online dictionary are words such as *"disgraceful"*, *"shameful"*, *"dishonourable"*, *"unworthy"* and *"inexcusable"*.

163. The LQC stated that, in assessing seriousness, the Tribunal would be entitled to take account of the judgement in the case of *Calhaem v GMC* [2007] EWHC 2606 (Admin) wherein it was stated that:

*"Mere negligence does not constitute "misconduct"… depending upon the circumstances, negligent acts and omissions which are particularly serious may amount to "misconduct"… a single negligent act or omission is less likely to cross the threshold of "misconduct" than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single negligent act or omission, if particularly grave, could be characterised as "misconduct"."*

164. From this the Tribunal noted that if it found that a single incident had occurred it could only find misconduct if it considered that Professor Thompson's failings were *"particularly grave"*.

165. The LQC stated that, on the question of whether the failings found amount to a single incident, the Tribunal shall take account of the respective submissions of the parties on the point, and if the Tribunal is persuaded that they do, then it may be assisted by the following online definition of *"particularly grave"* as something that "*is seriously bad, important or concerning, more so than usual. It emphasises the severity or seriousness of a situation, event or condition"*. The Tribunal was also to note the other terms referred to in the submissions such as *"gross neglect"* or *"culpable carelessness"*, and the reference to *"clinical failings*

*amounting to gross negligence… about a risk of serious harm to patients"* in the GMC guidance entitled 'Principles to inform impairment…'.

166. The LQC stated that if the Tribunal do find that Professor Thompson's actions amount to misconduct, it must then decide whether Professor Thompson's fitness to practise is impaired as a result of that misconduct. The Tribunal must determine whether Professor Thompson's fitness to practise is impaired today, taking into account his conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

167. In terms of impairment, the LQC referred to the approach set out by Dame Janet Smith in the Fifth Shipman Report, as referred to in the case of *CHRE v NMC & Grant* [2011] EWHC 927 (Admin), as follows:

*"Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination 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; and/or*
> *d. has in the past acted dishonestly and/or is liable to act dishonestly in the future."* (Not applicable in this case).

168. The LQC also referred to paragraph 94 in the case of *GMC v Sawati* [2022] EWHC 283 (Admin), with reference to *Sayer v General Osteopathic Council* [2021] EWHC 370 (Admin) that:

*"(1) Insight is concerned with future risk of repetition. To this extent, it is to be distinguished from remorse for the past conduct.*
*(2) Denial of misconduct is not a reason to increase sanction.*
*(3) It is wrong to equate maintenance of innocence with lack of insight. Denial of misconduct is not an absolute bar to a finding of insight. Admitting misconduct is not a condition precedent to establishing that the registrant understands the gravity of the offending and is unlikely to repeat it.*

*(4) However, attitude to the underlying allegation is properly to be taken into account when weighing up insight. Where the registrant continues to deny impropriety, that makes it more difficult for him to demonstrate insight.*
*(5) The assessment of the extent of insight is a matter for the tribunal, weighing all the evidence and having heard the registrant. The Court should be slow to interfere."*

169. The LQC stated that, having considered these matters, the Tribunal may find itself concluding that Professor Thompson was not currently impaired on a personal/public protection basis. However, this was not the end of the matter since there may be wider issues of public interest and public confidence in the profession which come into play. The case of *Grant* says:

*"The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case."*

## The Tribunal's Determination on Impairment

### Misconduct

170. The Tribunal first considered whether Professor Thompson's actions amount to misconduct.

171. The Tribunal has found proved that, on 29 August 2021, Professor Thompson failed to take more aggressive intervention from 12:00-13:00 in that he did not escalate Martha to the PICU team for a direct clinical review, and that Professor Thompson failed to conduct a direct in-person review and assessment of Martha from approximately 17:00 onwards on that same day. The Tribunal specifically found that Professor Thompson should have attended in person at the hospital at 17:00 and, if not then, at 20:30 following telephone conversations with Dr G, on the basis that Professor Thompson was advised of new developments, particularly the skin rash and BPEWS score of 8 at 17:00, and of the increased lactate level and continuing fevers (including high risk factors relating to heart and respiration rates) at 20:30.

172. The Tribunal first considered whether the paragraphs of the Allegation found proved amounted to a single incident. The Tribunal noted that both the failure to escalate Martha to

the PICU team and the failure to conduct an in-person review took place in one day over the course of about four hours from around 17:00 to 20:30. These two matters related to one patient and were connected in that they related to the monitoring and managing of the deterioration in Martha's condition. The Tribunal was of the view that the 'mischief' was Professor Thompson's failure to recognise how serious the situation was and not making the decision to escalate Martha's care. Further, it related to Professor Thompson's clinical judgement about Martha's condition at that time and did not relate to two different and distinct separate clinical decisions. The Tribunal determined that it was more likely than not that Professor Thompson's actions represented a single incident.

173. The Tribunal appreciated the evidence of Professor F that *"given the relentless progression of [Martha]'s physiological deterioration despite extraordinary levels of appropriate supportive care over 30-31 August 2021, it is my opinion, on the balance of probabilities, that even if [Martha] had been admitted to PICU at around 12.00-13.00 on 29 August 2021, then she still would have died."* The Tribunal fully understood that Martha's death was something which it had been advised not to take into account in its deliberations regarding misconduct and impairment.

174. The Tribunal noted the paragraphs of GMP that Mr Rose stated were engaged in this case as quoted above. The Tribunal determined that, although all of the paragraphs listed were engaged and relevant in this case, Professor Thompson's actions amounted to a breach of paragraph 15 and 16(b) of GMP only, which are:

*"15 You must provide a good standard of practice and care. <u>If you assess, diagnose or treat patients, you must:</u>*

*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 <u>necessary, examine the patient</u>.*

*b promptly provide or arrange suitable advice, investigations or treatment where necessary.*

*c refer a patient to another practitioner <u>when this serves the patient's needs</u>.*

*16 In providing clinical care you must:*

*… b provide effective treatments based <u>on the best available evidence</u>…"* (the Tribunal's emphasis)

175. The Tribunal was clear that Professor Thompson's actions were a breach of paragraph 15 of GMP in that he did not adequately assess Martha's condition and did not see her for a direct review, and further he did not refer Martha to another practitioner when this served her needs. The Tribunal was of the view that paragraph 16(b) of GMP was linked to paragraph 15 in that the best available evidence would have been possible by examining Martha directly.

176. The Tribunal considered whether Professor Thompson's omissions, which it has found to represent a single incident, were *"particularly grave"* such that they could be characterised as misconduct. It noted the definitions of *"particularly grave"* as set out above.

177. The Tribunal noted the breaches of GMP set out above. It considered that there was a fundamental and basic obligation on doctors to adequately assess a patient's condition and, where necessary, examine the patient (paragraph 15(a)) so as to ensure that they were in possession of "*the best available evidence"* (paragraph 16(b)). In Professor Thompson's case, the crucial points as far as the Tribunal was concerned were that, certainly by 20:30, three worrying and unexplained conditions had come into being, namely a rash which had proved difficult to diagnose, an increased lactate level, and ongoing and persistent fevers which featured high risk indicators regarding heart and respiratory rates as set out above, all suggesting Martha's further deterioration. Furthermore, at that time, Professor Thompson had not seen Martha since around midday, some 8½ hours earlier, so he was unable to see for himself how she presented. The Tribunal considered that this failure to go back to the hospital and see Martha for himself was not only necessary but was also a breach of such a fundamental obligation that it was therefore capable of being "*particularly grave*".

178. The Tribunal noted Mr Rose's submissions that, although it was not to take account of Martha's death when assessing the seriousness of Professor Thompson's failings, it was entitled to take account of the risk of death. The Tribunal noted how concerned all the clinicians involved in Martha's case were, and that she was very ill (indeed, being described as the sickest child on the ward). Moreover, the Tribunal noted Professor Thompson's evidence that complete severance of the pancreas was very rare but that the more severance there was, the more likely that such could have resulted in the death of the patient. The Tribunal appreciated that it was suggested that only around two deaths had occurred on the ward over the previous 20 years due to severance of the pancreas and therefore that it may have appeared unlikely that Martha would die due to complete severance, but the Tribunal considered that there was, nonetheless, an increased risk of death in her case which should have been foremost in Professor Thompson's mind.

179. The Tribunal noted that, at some stage after the first telephone call between Dr G and Professor Thompson, there was a second bolus. Martha's blood pressure increased (albeit it was still below 100), and Professor Thompson was told at 20:30 that Martha's blood pressure was still the same. The Tribunal was clear that there was no criticism of Professor Thompson for sticking to the plan as far as blood pressure was concerned. However, the Tribunal also noted that Professor Thompson was told at around 17:00 about the BPEWS score rising to 8. The Tribunal noted Ms C's comments that: *"*[Ms C] *said that she would definitely not rely on BPEWS chart on RoS ward.* [Ms C] *explained that liver patients can be incredibly complex and very ill but their BPEWS score may be really low. In her opinion BPEWS tool can be very helpful when a patient scores are high and people start paying more attention".* The Tribunal noted that Ms C's evidence more or less echoed Professor Thompson's evidence about the usefulness of BPEWS, but regarded the need to "*start paying more attention*" as an additional factor obliging him to return to the hospital and see Martha for himself.

180. Furthermore, the Tribunal reminds itself that there was some discussion between Dr G and Professor Thompson at 20:30 regarding not wishing to upset Martha's parents by having PICU arrive unannounced. Another advantage, therefore, of returning to the hospital would have been that Professor Thompson would be on hand to personally discuss such a development with the parents.

181. With regard to the involvement of PICU, the Tribunal considered that paragraph 15(c) of GMP (regarding a doctor's duty to refer a patient to another practitioner when this serves a patient's needs) described another fundamental obligation on doctors. On this point, the Tribunal noted the additional evidence of Ms C, in her account of events that:

*"On the night shift of the 29th August 2021 the liver registrar on call called me late evening. He clearly stated that he wasn't acutely worried about Martha, but asked if it was worth getting an HDU review due to her chronic deterioration, her query DIC episode previously, her recent developed rash, her continued pyrexia. I responded stating that if there is ever a situation where anything is unsure whether to get an HDU review, then they should always get one."* (Tribunal's emphasis)

182. The Tribunal was of the view that this should have been Professor Thompson's position in respect of Martha at the index time, particularly since he was not a Consultant in paediatric intensive care, and that his failure to refer Martha to PICU was capable of being "*particularly grave*".

183. In summary, the Tribunal was of the view that, as more serious and unexplained factors had come into play, there were clear points (at 17:00 and 20:30) when Professor Thompson should have taken action not only to see Martha himself but also to refer Martha to PICU and these combined failures to do so makes them more serious. The Tribunal appreciated that it was assisted by hindsight but concluded that there were sufficient adverse clinical indicators at the time of something unexplained going on such that direct review and escalation to PICU was required.

184. In particular, the Tribunal considered that Professor Thompson was not being required to make a decision to do something inherently risky, but was being required to better inform himself of Martha's condition by direct observation, and whether or not to obtain a third-party opinion. On the face of it, these were not actions which carried any particular risk, but the real risk lay in the greater possibility of a serious outcome if he did not do these things. Hence there was no sound reason for not taking the required action.

185. Taking all these factors into account, the Tribunal was of the view that Professor Thompson's omissions were *"particularly grave"* and essentially amounted to gross negligence about the serious risk of harm to patients (albeit only on this one occasion) and were sufficiently serious in any event such as to amount to misconduct. Consequently, the Tribunal has concluded that Professor Thompson's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor so as to amount to misconduct.

Impairment by reason of misconduct

186. The Tribunal, having found that the facts found proved amounted to misconduct, went on to consider whether Professor Thompson's fitness to practise is currently impaired by reason of his misconduct.

187. With regards to remediation, the Tribunal considered whether Professor Thompson's actions were easily remediable. It determined that they were in that there was an easily identifiable correction such that Professor Thompson would come into the hospital and directly review the patient if anything similar ever arose again.

188. The Tribunal considered whether Professor Thompson had remediated his misconduct. The Tribunal has been provided with evidence to show that Professor Thompson has changed his approach. The Tribunal heard that Professor Thompson voluntarily restricted

his work after continuing with it for the six months after Martha's death. The Tribunal agreed that this showed that Professor Thompson was sensible and acting safely given the inefficiencies he identified in his own approach due to the cautious attitude he had developed.

189. In respect of insight, the Tribunal accepted that Professor Thompson has clearly agonised over these events over the last four years and has shown himself to be a doctor who has demonstrably reflected extensively on the events of his care of Martha. He has shown significant remorse for his actions. Whilst the Tribunal appreciated that Professor Thompson's views on what would have been the right thing to do have gone back and forth, it determined that Professor Thompson understands the gravity of his misconduct, understands what has happened, and what he should have done differently. The Tribunal was of the view that Professor Thompson has demonstrated that he is someone who is willing to listen, learn and reflect.

190. Furthermore, notwithstanding that Professor Thompson has indicated that, currently, he did not think that he made the wrong decision at the time, the Tribunal has taken account of the cases of *Vali* and *Sawati* referred to above and has concluded that, even though it may be more difficult for Professor Thompson to demonstrate insight, he has, nonetheless, done so.

191. The Tribunal referred to the CPD and testimonials before it. It considered that they showed a competent clinician who is well regarded and works well with patients. He has shown a willingness to be reflective and is someone who is cautious to ensure that no patients are put at risk.

192. Having regard to the risk of repetition, the Tribunal noted that it needed to view this with the understanding that Professor Thompson could well return to undertaking inpatient clinical work in the future. In all the circumstances, the Tribunal was of the view that Professor Thompson would be very unlikely to repeat the misconduct. It considered that the risk of repetition was almost non-existent. The Tribunal was of the view that if an exact or similar situation arose Professor Thompson would undertake a direct review and refer to PICU. He has demonstrated that he has a heightened appreciation about coming into the hospital to make face to face assessments of patients.

193. On this point, the Tribunal notes Professor Thompson's evidence to the inquest on 22 February 2022, where he stated:

"*I think many of us, me in particular, have reflected on the sequence of events and I think I was falsely reassured. I think there were clearly signs of sepsis, there is absolutely no question about that whatsoever, she was unwell and I was reassured by some of the blood tests and some of the physiology. I think maybe underestimated other aspects of the physiology which I should have placed more emphasis on, so that is a very sobering lesson to me… No, at the time, as I keep saying I am afraid I was reassured by some of the parameters which in full light of events turned out to be a false reassurance and I would outweigh the different factors slightly differently next time without any question, but at the time that seemed the correct decision… I certainly accept that it was the wrong decision and that's the best I can do. Obviously, at the time, I thought I made the correct decision in hindsight with all the information available now, clearly, an opportunity was lost. If I was put in the same position again, knowing what I do know now I will do something different...*" (The Tribunal's emphasis).

194. The Tribunal considers that this is strong evidence that, just six months after the event, Professor Thompson was already demonstrating clear insight as to what he would do differently should the circumstances he was faced with on 29 August 2021 ever be repeated.

195. The Tribunal has considered the submissions of Mr Rose set out as follows:

"22…*It is important to remember that what is being considered is whether Prof Thompson is fit to practise without restriction in any clinical role that he could reasonably undertake as a Consultant Hepatologist. It is not restricted to considering whether he is fit to practise in his current role which he has voluntarily restricted, on his evidence as a result of the impact which these events had on him. In short, you should consider whether he is fit to practise in his old role, should he return to it at some stage in the future.*

*23. However, the fact that he has voluntarily practised in a restricted role since these events occurred means you have limited practical evidence in which to assess whether or not he has remediated. Rightly or wrongly, Prof Thompson considered that he was not safe to continue practising in his existing role, either because of the effect which the events you are concerned with had had on* [XXX]*, or because he had become excessively cautious or because he doubted his own judgement, and has consequently undertaken a very different role within KCH – dealing with outpatient referrals and undertaking academic research – for much of the time since these events occurred. He has not treated acutely unwell paediatric patients. Whilst, therefore, there is no evidence of any subsequent concerns arising, there has been no*

*opportunity to assess Prof Thompson's performance in the sort of situation which gave rise to the misconduct that will have been found proven if the Tribunal is considering this stage. It follows that his work since these events can only provide limited assistance in determining whether or not Prof Thompson has remediated.*"

196. The Tribunal noted Mr Rich's submissions in response. He stated that the evidence is that Professor Thompson did not decide that he was not safe to practise but that he noted that he was practising sub-optimally in that he had a lack of confidence in his own judgment and was regularly double-checking his clinical decisions. Mr Rich maintained that this did not indicate unsafe practice but precisely the opposite, namely that he practised safely and could manage such risk. His failings on 29 August 2021 were a misjudgement on one occasion in a very long and distinguished career.

197. The Tribunal preferred Mr Rich's arguments to those of Mr Rose on this point. It agreed that Professor Thompson's current practice, although not optimal, was clearly safe. Further, it considered that, if the Tribunal allowed him to practise without restriction, and Professor Thompson returned to his old role, his previous relevant experience and continuing involvement at the periphery of in-patient care (for instance by still attending MDT meetings) would enable him to pick up his previous practice, albeit that he might practise more cautiously. This would still, however, be safe practice and therefore would not lead to any public protection issues.

198. The Tribunal therefore concluded that, in terms of public protection and his individual practice, Professor Thompson has remediated on a personal basis. It found that it is highly unlikely that anything like this will ever happen again and there is no current impairment of Professor Thompson's fitness to practise on this basis.

199. The Tribunal next considered, as referred to in the case of *Grant*, *"whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case".* The Tribunal had regard to all the circumstances in this case and to its findings that there had been breaches of paragraphs 15 and 16(b) of GMP because of Professor Thompson's failings. The Tribunal concluded that the misconduct was such that a finding of impairment was required to uphold public confidence in the profession as well as uphold proper professional standards, and that it would be undermined if no finding of impairment were found. There had been a significant potential risk of harm to Martha and it was appropriate to send a message to the profession as to the importance of

following the basic and fundamental principles as set out in GMP so as to ensure that the potential risks of an adverse outcome are always taken into account.

200. Moreover, the Tribunal considered that the public would be reassured that doctors were being reminded in no uncertain terms of the importance of always applying the basic and fundamental principles of clinical care to their practice.

201. The Tribunal has therefore determined that Professor Thompson's fitness to practise is impaired on public interest grounds by reason of his misconduct.

## Determination on Sanction - 11/06/2025

202. Having determined that Professor Thompson'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

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

## Submissions

### Submissions on behalf of the GMC

204. Mr Rose referred the Tribunal to various paragraphs of the Sanctions Guidance (5 February 2024) ('the SG'), including paragraph 16 which underlines the point that sanctions are not imposed to punish or discipline doctors, but they may have a punitive effect. Mr Rose stated that the Tribunal was approaching the basis of sanction in terms of the need to maintain public confidence and standards in the profession, as opposed to a sanction that is there to protect patient safety. Mr Rose stated that, at paragraph 17 of the SG, *"patients must be able to trust doctors with their lives and health, so doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession"*, which is also a reference to paragraph 65 of GMP. Mr Rose stated that, again with reference to paragraph 17 of the SG, although the Tribunal should make sure the sanction it imposes *"is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor".*

205. In terms of aggravating and mitigating factors, Mr Rose submitted that these would need to be read in the context of the Tribunal's determination on Impairment. He stated that none of the aggravating factors that the SG identifies were applicable in this case but that was not to say that there were not any aggravating factors. Mr Rose submitted that the Tribunal had identified these in its determination on Impairment.

206. Mr Rose submitted that, although undoubtedly a high-profile case, it is not an exceptional one. He stated that the misconduct found proved involved quite basic matters in terms of the failure to examine and the failure to refer. Mr Rose stated that there was no evidence of any wider external factors or any significant mitigation to elevate this case into such an unusual or uncommon place where there were exceptional circumstances on the index day such as to justify taking no action. He stated that the purpose of a sanction is for the Tribunal to address the impairment that it has found given the seriousness of the misconduct and the gravity of the findings to address the impact on public confidence and the need to maintain standards in the profession. Mr Rose submitted that no action would not do this and would, in fact, almost run counter to the need to send out a message so that the public know that the profession are being told that such misconduct is unacceptable. Mr Rose submitted that taking no action would be inconsistent with the Tribunal's impairment finding and give raise to a great deal of uncertainty as to the Tribunal's approach to misconduct. Mr Rose asked the Tribunal to look at the particular factors leading up to its findings of misconduct and impairment. He reiterated that there was nothing exceptional here.

207. Mr Rose submitted that, if the Tribunal was to take no action, the subtlety of that approach would be lost amongst the public and might well also be lost amongst the profession. Mr Rose submitted that the Tribunal has found misconduct that it has characterised as a departure from the required standards. Mr Rose submitted that, notwithstanding Professor Thompson's personal remediation, there was a need to maintain public confidence in the profession and uphold standards such that a finding of impairment was made. Mr Rose submitted that no action being taken would leave that impairment finding floating in the air and that an appropriate sanction was required to send the relevant 'message' given the seriousness of the fundamental and grave failings found. He submitted that the message was to the wider public and the wider profession and taking no action would not convey that message adequately.

208. Mr Rose submitted, in light of the Tribunal's ruling on impairment, that there was no discernible basis for making an order of conditions. He stated that conditions are there to address a specific problem or set of problems that the Tribunal has established; this is not the case here. Mr Rose referred to the Tribunal's finding as to Professor Thompson's insight and remediation. He posed the question as to what conditions the Tribunal could sensibly impose that would have merit or perform some sort of purpose.

209. Mr Rose submitted that conditions, in of themselves, could not be a 'message'. He stated that the Tribunal has found that impairment of Professor Thompson's fitness to practise comes from the seriousness of what he has done and that there was therefore a need to have a sanction that upholds public confidence and standards in the profession. Mr Rose submitted that conditions could not do this.

210. Mr Rose submitted that, rather, this is a case which calls for a 'message' to be sent out to the profession and to the public at large. He referred to the Tribunal's comments in its determination on Impairment, including that it *"… was appropriate to send a message to the profession as to the importance of following the basic and fundamental principles as set out in GMP…"*

211. Mr Rose submitted that this was entirely consistent with the guidance provided at paragraph 91 of the SG, which reads:

*"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."*

212. Mr Rose submitted that paragraphs 92 and 93 of the SG were engaged in this case:

*"92. Suspension will be an appropriate response to misconduct that is so serious that action must be taken to… maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration…*

*93. Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is*

*unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions…"*

213. Mr Rose stated that the GMC make no submission as to length of any suspension as it is a matter for the Tribunal's own independent discretion based on the guidance. Mr Rose stated that, in light of the Tribunal's findings as to the unlikelihood of any repetition and the fact that Professor Thompson does not pose a risk to patient safety, the GMC does not submit that a review is necessary in this case.

Submissions on behalf of Professor Thompson

214. Mr Rich stated that the index events did not involve some kind of neglectful or deliberate piece of misconduct; it arose out of a serious misjudgement that was made in good faith. Mr Rich submitted that there were significant mitigating circumstances in this case and referred to the insight and remediation shown by Professor Thompson.

215. Mr Rich submitted that the purpose of the sanction is to maintain confidence in the profession, to declare and uphold standards, and maintain confidence in the regulatory process. He stated that that Professor Thompson is an internationally renowned expert on liver disease, particularly in its genetic variants and with an emphasis on paediatric liver disease. Mr Rich stated that Professor Thompson has been a 'go to' colleague for many liver specialists, as in the words of Professor M: *"particularly when it came to looking after children growing into adulthood with unusual biliary or cholestatic disorders what we would never have seen before"*. Mr Rich stated that Professor Thompson consults and provides advice on patients around the world, as well as in the UK.

216. Mr Rich referred to a number of other testimonials on behalf of Professor Thompson, in that:

- Dr O states: *"He is often the person that is approached for challenging clinical cases, especially in multidisciplinary meetings"*.

- Professor P pays tribute to the outstanding quality of his work in the King's College MDT meetings and says: *"his absence is usually felt when he is away"*.

- Dr Q has described the specialist multi-disciplinary meeting Professor Thompson set up to discuss genomic results in patients with hereditary cholestasis. She states: *"His*

*expertise at these meetings in invaluable and he has an unrivalled understanding of the most recent literature related to the management of these complex adult and paediatric patients"*. Mr Rich stated that this was an online national multi-disciplinary meeting where doctors from around the country (and not just KCH) can consult with Professor Thompson and seek his advice.

217. Mr Rich stated that this is a case where a finding of impairment is a very significant thing for the doctor involved. He submitted that it should not be underestimated how stigmatising, not to say humiliating, it is for a doctor of Professor Thompson's distinction to be told that his fitness to practise has been impaired as his practise was substandard in an important way. Mr Rich submitted that this was a very considerable issue.

218. Mr Rich stated that the GMC has said that, to take no action, the Tribunal has to find something exceptional about the index day in question. He submitted that this exceptionality does not have to come from the events themselves and could be found in the wider circumstances. Mr Rich stated that the additional effect of the publicity in this case, where Professor Thompson's name has been across the press as a doctor who failed in his duty towards a patient, was also a profound issue and the interest, that perhaps a more junior doctor would not attract, had to be factored in.

219. Mr Rich submitted that an order for erasure would be wholly disproportionate and contrary to the public interest given the context where the Tribunal found that the misconduct amounted to a single incident with one patient and it had been remediated by changes in the way Professor Thompson practised after the incident and would practise in the future. Mr Rich stated that Professor Thompson, with reference to the Tribunal's determination on Impairment, had *"clearly agonised over these events over the last four years"*, *"shown significant remorse for his actions"* and *"demonstrated that he is someone wo is willing to listen, learn and reflect"*. Mr Rich stated that Professor Thompson has demonstrated insight and the Tribunal has concluded that *"the risk of repetition was almost non-existent"*.

220. Mr Rich submitted that Professor Thompson should be subject to an order of conditions, not a suspension. He submitted that this is a case in which the public interest in keeping a safe doctor in practice should weigh heavily. Mr Rich submitted that the sort of advice given by Professor Thompson was not replaceable, nor was it necessarily the case that decisions about the management of challenging patients could wait until any suspension imposed by the Tribunal has come to an end. Mr Rich stated that it was likely that the

imposition of a suspension would prevent some patients getting highly specialised advice at the time they need it, with an obvious possibility of actual patient harm.

221. Mr Rich submitted that, while this case is not a paradigm case for conditions - as they are usually imposed to correct some defect in performance, the regulatory regime is flexible enough to accommodate rare circumstances. Mr Rich submitted that, if anything, public confidence in the regulatory system was likely to be undermined if the sanction regime was applied so inflexibly that a clear public interest cannot be met. Mr Rich submitted that if it was not possible to say that conditions can be approached flexibly in the way suggested then perhaps this is an unusual, exceptional or uncommon case in which the Tribunal should take no action.

222. Mr Rich submitted that the findings of misconduct and impairment and the fact of the imposition of an order of conditions would be sufficient to send a deterrent message to the profession and maintain public confidence. Mr Rich submitted that this would not suggest to other members of the profession that they could fall short of required standards in a similar way with impunity as conditions are a significant sanction which is onerous and stigmatising. Mr Rich stated that, while such an order did not prevent a doctor practising altogether, it was something no doctor would wish to have imposed on them. Mr Rich submitted that very few doctors will have the very rare level of specialised expertise that Professor Thompson has, which would give rise to such a strong public interest in not taking them out of practice even temporarily.

223. Mr Rich stated that the Tribunal was urged to impose an order of conditions involving supervision on Professor Thompson's registration. Mr Rich stated that, if the Tribunal felt this was not onerous enough, it could restrict Professor Thompson from seeing acute patients in the ward setting (as opposed to outpatient clinics), or even ban him from seeing any patients face to face. The latter would confine Professor Thompson for a period to giving the specialised advice to colleagues who would retain responsibility for the management of the cases. Mr Rich stated that this would be similar in effect to a suspension but with an exclusion for the less replaceable advice work. Mr Rich submitted that the Tribunal could properly take this more positive and creative approach which would answer the interests of the profession following the finding of impairment, without unnecessarily prejudicing individual patients.

224. Mr Rich submitted that, if the Tribunal found that a suspension was necessary to meet the statutory objective, the suspension should be as short as possible to limit the damage to patient care.

## The Tribunal's Determination on Sanction

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

226. In reaching its decision, the Tribunal has taken account of the SG and of the overarching objective. It noted that the SG can be departed from for good reason. 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.

### Aggravating and mitigating factors

227. The Tribunal had regard to the examples of aggravating factors that are suggested within the SG, such as a lack of insight, a previous finding of impairment or in respect of the circumstances surrounding the event. The Tribunal agreed with Mr Rose that it was unable to find in the SG any factors in this case that could be characterised as 'aggravating' additional to those already identified in the Tribunal's decision on impairment.

228. In terms of mitigating factors, the Tribunal considered that almost all of the mitigating factors set out in the SG were applicable to this case. The Tribunal was of the view that Professor Thompson clearly *"understands the problem and has insight"* in line with paragraph 25(a) of the SG. It has found that Professor Thompson has reflected extensively on the events of his care of Martha and has shown significant remorse for his actions. Further, the Tribunal has evidence of Professor Thompson's remediation. It has found that Professor Thompson has remediated on a personal basis. The Tribunal considered, in its determination on Impairment, that the testimonials provided showed a competent clinician who is well regarded and works well with patients. The Tribunal has also previously found that Professor Thompson has shown a willingness to be reflective and is someone who is cautious to ensure that no patients are put at risk.

229. The Tribunal has found, in respect of mitigation, that Professor Thompson has no adverse previous fitness to practise history within nearly 40 years of practice and there has been no repetition of the index event either before or since. It also noted its conclusions in its

determination on Impairment that the risk of repetition was almost non-existent. The Tribunal has been provided with evidence that Professor Thompson has maintained his medical skills and knowledge and has remained cognisant throughout of working within his competence, taking a step back from in-patient care and focusing on outpatient and research work.

230. The Tribunal found Professor Thompson to be someone who has always been willing to listen and learn and wanting to confront what he knows was a serious concern. The Tribunal was of the view that Professor Thompson has continued with that approach to date and was unable to find anything else he could do to try and put right the wrongs of the past. The Tribunal also noted that Professor Thompson has willingly engaged in the various enquiries and proceedings in respect of Martha's care in the past four years, during which he has accepted responsibility as the clinician in charge by not seeking to pass blame onto others or the acknowledged deficiencies in the Trust procedures at the time. This point is particularly relevant since it is apparent to the Tribunal that there were matters of which Professor Thompson was unaware, such as the failure to take Martha's BPEWS readings between 14:00 and 16:45 and the failure to implement a third bolus and escalate Martha's case to PICU when her blood pressure readings dropped significantly at 20:45. This was a clear contradiction of the instruction that Professor Thompson had provided that evening. Both of these failings, in respect of which no allegations were made against Professor Thompson, more likely than not also contributed towards the ultimate deterioration in Martha's condition.

231. Further, the Tribunal noted the evidence of Dr E which detailed the apparent acceptance by KCH of systemic failings on the Ward in that, since the incident, there was a realisation that the Critical Care Unit was typically full or over capacity, which created challenges in not having enough staff to support deteriorations on the ward but also led to a lack of beds on critical care. This led to Trust investment in a 24-hour Critical Care Outreach team for Paediatrics which is composed of nursing and/or medical staff who are solely responsible for taking referrals across the wards, reviewing deteriorating patients and supporting their stabilisation. Further, the Trust moved from paper BPEWS charts to electronic in 2024 following national recommendations. The scoring, with recommendations, remains based on physiological parameters. Each Ward Manager and the Critical Care Outreach Service are able to see the BPEWS score for their ward instantly and electronically.

232. In addition, it was realised that the process for referral to Critical Care in 2021 was not clear. Whilst typically the HDU registrar would be called, they were independent practitioners

and so, at times, might not have been available or busy with unwell patients. Often, there would be a discussion with the PICU registrar to see who could review the patient being referred. Consultant to consultant referrals were common but, at the time, the process was not clarified, with no clear documentation noting when a referral occurred. Since 2021, a new escalation policy has been designed, with clarity in referral processes and criteria. The criteria for referral has been lowered and defined more clearly. Referrals are now documented via the electronic patient record. Emphasis has been put on parental concern and training with the medical and nursing teams regarding appropriate ways to escalate concerns.

233. Finally on this issue, it became apparent that there were staffing issues on the Ward. In 2021, the medical staffing for the Ward overnight included a resident doctor grade ST2-3 (SHO) or equivalent. This was typically a junior doctor who had 2-3 years of paediatric experience and typically would have no experience in Paediatric Hepatology prior to joining the team. There was access to a registrar grade doctor, of typical experience of 4 or more years in Paediatrics, but they were non-resident and only available by telephone overnight. They would have the opportunity to return to the hospital if there was an emergency but otherwise were expected to reside off site away from the hospital. The consultant was non-resident at home and available for telephone advice or to return to the hospital in the event of an emergency. The SHO, at the time, had a large workload of managing 18 patients, responding to patients and to parent and nursing requests and ensuring appropriate tests were done and reviewed. Given the challenge around the high workload for the SHO on the Ward, and grade of doctor, multiple changes have been made. The first is that a handbook has been designed for the resident doctors with clear guidance around the function of the Ward, acuity of patients and the escalation processes. The Trust has also implemented a 24-hour resident rota on the Ward for two doctors, both the SHO grade and registrar grade to aid the workload; this rota also allows for more senior paediatric support to be accessible immediately for the Ward.

234. In conclusion, therefore, it was apparent to the Tribunal that these multiple changes in the practice on the Ward indicated the presence of systemic failings on the Ward on 29 August 2021, which the Tribunal considers should also be taken into account as a mitigating feature.

No action

235. The Tribunal was mindful that its approach when deciding what sanction, if any, to impose was that it should consider the sanctions available starting with the least restrictive. It had regard to the principle of proportionality, weighing the interests of the public against those of Professor Thompson.

236. In coming to its decision, the Tribunal considered whether to conclude the case by taking no action on Professor Thompson's registration.

237. With reference to paragraph 68 of the SG, the Tribunal was clear that it is the usual position that impairment of a doctor's fitness to practise is such that it is necessary to take action to protection the public *"but there may be exceptional circumstances to justify a tribunal taking no action"*. It noted the absence of any legal precedents on this issue. It did, however, agree with Mr Rich that exceptional circumstances were not just confined to the events on 29 August 2021 but could encompass other factors - the SG was silent as to specifics on this matter.

238. The Tribunal referred to its findings and the comments made as to misconduct and impairment. It has taken account of the level of Professor Thompson's insight and remediation. The Tribunal was conscious of paragraph 69 of the SG in that these mitigating factors of insight and remediation *were "unlikely on their own to justify a tribunal taking no action"*.

239. The Tribunal had regard to paragraph 70 of the SG in that:

*"Exceptional circumstances are unusual, special or uncommon, so such cases are likely to be very rare. The tribunal's determination must fully and clearly explain:*

*a. what the exceptional circumstances are*
*b. why the circumstances are exceptional*
*c. how the exceptional circumstances justify taking no further action."*

240. The Tribunal had regard to the factors it has listed above as to mitigation. It also had regard to its findings including its comments in its determination on Impairment that:

*"the failure to escalate Martha to the PICU team and the failure to conduct an in-person review took place in one day over the course of about four hours from around 17:00 to 20:30. These two matters related to one patient and were connected in that they related to the monitoring and managing of the deterioration in Martha's condition. The Tribunal was of the view that the 'mischief' was Professor Thompson's failure to recognise how serious the situation was and not making the decision to escalate Martha's care."*

241. The Tribunal noted the work Professor Thompson is currently undertaking, including the specialist advice that he provides both internationally and in the UK. It appreciated the seriousness of the misconduct/impairment found but that any action it took would also need to be proportionate, including the value in not depriving the public of a safe and competent doctor.

242. The Tribunal appreciated that some may be of the view that taking no action on Professor Thompson's registration would not enhance the message it was sending out. It disagreed. The Tribunal was of the view that the finding of misconduct and impairment, notwithstanding all of Professor Thompson's expertise and experience, does still send a clear and meaningful message. It is in the public domain, does have an effect on Professor Thompson, and alerts members of the profession to ensure that they follow the principles set out in GMP. The Tribunal considered that other members of the profession would clearly understand that, despite Professor Thompson's experience and reputation of excellence in his chosen field of Hepatology, he still made a very serious error of clinical judgement regarding a basic and fundamental part of a doctor's practice, sufficient to amount to misconduct, and had a finding of impairment against him. The Tribunal considered that this finding, by itself, would send out a clear message to the profession that even a doctor of Professor Thompson's experience and renown would, to put it in common parlance, 'not get away with it' and would encourage other doctors to ensure that they practised at an optimum level. The fact that a doctor of 40 years standing could make one serious clinical misjudgement and as a result receive a finding of misconduct and impairment, would be a formidable lesson to any doctor. Similarly, the same message would, in the Tribunal's opinion, be clearly understood by members of the public. The Tribunal did not agree with Mr Rose's submission that the nuance of the finding of impairment against Professor Thompson would be lost and would only be understood if a suspension order was made.

243. The Tribunal therefore determined that its finding of impairment was a very significant thing for Professor Thompson and should not be disregarded.

244. The Tribunal was mindful, with reference to paragraph 21 of the SG, that once it has determined *"that a certain sanction is necessary to protect the public (and is therefore the minimum action required to do so), that sanction must be imposed, even where this may lead to difficulties for a doctor"*. Given the submissions made by the parties, the Tribunal did look ahead to assess whether a sanction of conditions would be appropriate. It noted, with reference to paragraph 81 of the SG, that conditions might be most appropriate in cases involving the doctor's health, involving issues around the doctor's performance, where there is evidence of shortcomings in a specific area or areas of the doctor's practice or where a doctor lacks the necessary knowledge of English to practise medicine without direct supervision. The Tribunal took account of Mr Rich's submissions that, while this case is not a paradigm one for conditions; the regulatory regime is flexible enough to accommodate rare circumstances. The Tribunal was of the view that imposing conditions in this case would be unnecessary and artificial. It considered that it was being asked to bend the conditions of practice to fit a specific situation. It appreciated that the suggested period of supervision might allow time for a return to acute work but ultimately did not consider that conditions were satisfactory, appropriate or proportionate.

245. The Tribunal noted the relevant paragraphs of the SG in respect of suspension, including paragraphs 91 to 93 as quoted above, and the submissions from Mr Rose as to the suitability of a period of suspension. As stated above, the Tribunal did not think the nuance would be lost as to the message being sent as to its finding of impairment. It did not consider a period of suspension to be appropriate or proportionate in this case and would merely deprive the public of a good doctor without sufficient justification. The Tribunal was in no doubt that it has to send a message but considered that this had already been done in clear and robust terms.

246. In conclusion, the Tribunal considered that there were exceptional circumstances to justify it taking no action in Professor Thompson's case. It noted that *"exceptional"* circumstances were *"unusual, special or uncommon"*. The Tribunal first identified what it considered were the components of such exceptional circumstances:

i. Professor Thompson had no previous regulatory history and there has been no repetition of his failings since August 2021;
ii. He had made a one-off error of clinical judgement, so serious as to amount to gross negligence;
iii. He had fully remediated his failings and therefore there were no outstanding public protection issues;

iv. There was no allegation or evidence that Professor Thompson either caused or contributed to Martha's death;

v. The finding of misconduct and impairment was in any event a significant stigma on an otherwise successful career and would be a continuing embarrassment for Professor Thompson;

vi. Professor Thompson had not sought to blame others, notwithstanding that it was apparent that there were other failings in respect of Martha's treatment during 29 August 2021, about which he was unaware;

vii. There were systemic failings regarding how the ward functioned with regard to referrals to ICU/PICU (as set out above) which had since 29 August 2021 been changed significantly;

viii. The other possible sanctions are not appropriate and would involve either: undue manipulation of the criteria for such a sanction in order to comply with the SG (for instance a conditions of practice order); or would result in the loss of Professor Thompson's invaluable expertise as a Hepatologist, both nationally and internationally, if he was made subject to a suspension order of whatever length, which would not be in the public interest. Finally, a sanction of erasure was clearly disproportionate and contrary to the public interest, particularly since none of the factors referred to in the SG on the point apply to Professor Thompson's case;

ix. A sufficiently clear message had already been sent to the profession and to the public (that even such an experienced doctor as Professor Thompson could still make serious errors of clinical judgement for which he will be called to account). The public would be aware that this finding would remain a stain on Professor Thompson's reputation for the rest of his life.

247. The Tribunal concluded that the combination of these factors was what was unusual, special and uncommon and therefore amounted in total to exceptional circumstances. Finally, the Tribunal concluded that this combination justified taking no further action, particularly since the alternative sanctions were unsuitable for the reasons outlined above.

248. In conclusion, the Tribunal therefore determined to take no action on Professor Thompson's registration. It concluded that this was the most appropriate course in all the circumstances and reiterated that its original finding of impairment was such as to send the message to the profession to the importance of following the basic and fundamental principles as set out in GMP. The Tribunal felt that this message was clear and that the public would be reassured that doctors are being reminded of the importance of always applying the basic and fundamental principles of clinical care to their practice. The Tribunal did not

consider that taking no action detracted from the message that its determination on Impairment sent.

249. Finally, the Tribunal reminded itself that the reputation of the profession is more important than the impact of sanction on the registrant. However, Professor Thompson has done everything possible to address his failings. The Tribunal considered that the best way to repair any harm caused by his failings, would be for him to continue to provide his specialist expertise at home and abroad. To now, some four years after the index event, remove Professor Thompson from practice, even for a short period of time, for one single lapse of judgement in an otherwise exemplary career would, in the Tribunal's view, would be akin to punishment, which is not the role of the MPTS.

250. Further, the Tribunal determined that taking no action would, for the reasons stated above, uphold the overarching objective in terms of the need to promote and maintain public confidence in the profession, and to promote and maintain proper professional standards and conduct for members of the profession. For completeness and given its conclusions in its determination on Impairment, the Tribunal was of the view that this decision to take no action did not jeopardise public protection, particularly given its comments as to the risk of repetition.

251. The interim order on Professor Thompson's registration is hereby revoked.