PUBLIC RECORD

The GMC successfully appealed decisions of this Tribunal. Parties agreed by consent that a sanction of 12 months suspension should be substituted and that the doctor's name be erased from the Medical Register.

A copy of the appeal judgment is not accessible online for free. The name of the case is GMC v Kidd, the case number is AC-2026-LON-001825. If you wish to view the judgment you can contact the High Court direct to obtain a copy.

Dates: 23/02/2026 - 13/03/2026

Doctor:	Dr Desmond KIDD
GMC reference number:	3142769
Primary medical qualification:	MB BCh 1986 Queens University of Belfast

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

Summary of outcome

Suspension, 12 months.
Review hearing directed
Immediate order imposed

Tribunal:

Legally Qualified Chair	Miss Ruona Iguyovwe
Lay Tribunal Member:	Ms Rama Krishnan
Registrant Tribunal Member:	Dr Laura Florence

Tribunal Clerk:	Mr Laurence Millea (23/02/2026 to 25/02/2026) Mrs Jennifer Ireland

Attendance and Representation:

Doctor:	Not present, not represented
Doctor's Representative:	N/A
GMC Representative:	Mr Terence Rigby, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 06/03/2026

1. This determination was handed down in public. However, the Tribunal exercised its powers under Rule 41 of the General Medical Council ('GMC') (Fitness to Practise) Rules 2004, as amended ('the Rules'), to sit in private when the matters under consideration were confidential.

Background

2. Dr Kidd qualified in 1986. Prior to the events which are the subject of the hearing, Dr Kidd practised as a Consultant Neurologist, whose particular area of interest was neurosarcoidosis. At the time of some of the alleged events, Dr Kidd was practising as a Consultant Neurologist at the Royal Free London NHS Foundation Trust ('the Trust') and held practising privileges at the Royal Free Private Patients Unit ('the Unit').

3. The allegations that have led to Dr Kidd's hearing relate to his conduct. It is alleged by the GMC that between June 2019 and July 2020, whilst employed at the Trust, Dr Kidd produced and/or contributed to articles in which he dishonestly stated an affiliation with the Institute of Immunity and Transplantation within University College London.

4. It is further alleged that between 7 July 2020 and 1 February 2022, Dr Kidd acted dishonestly whilst providing treatment to Patient A and Patient B. It is also alleged that,

following his departure from the Trust and the Unit, Dr Kidd continued to correspond with patients who were no longer under his care regarding their medical conditions and/or treatment and acted dishonestly in that he later denied doing so. It is alleged that on one or more occasion, following his departure, Dr Kidd attempted to access medical records or information for patients he had previously treated.

5. The initial concerns were raised with the GMC on 29 November 2022 by Dr T, Responsible Officer ('RO') at the Royal Free Hospital ('the Hospital'), when a Maintaining High Professional Standards ('MHPS') investigation had been initiated in March of 2022. At that point Dr Kidd resigned his post, and subsequently ceased working at the Hospital on 31 August 2022.

The Outcome of Applications made during the Facts Stage

6. The Tribunal determined that service of the notice of this hearing had been effected in accordance with the Rules and paragraph 8 of Schedule 4 to the Medical Act 1983, as amended. The Tribunal determined to proceed with the hearing in Dr Kidd's absence in accordance with Rule 31 of the Rules. The Tribunal's full decision on this matter is included at Annex A.

7. The Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the Rules, to amend typographical errors at paragraph 30(b), and 30(h) of the Allegation later on in the hearing. The Tribunal was satisfied that there would be no injustice to Dr Kidd in making these amendments.

8. During the course of the fact-finding stage, the Tribunal noted that there was an inconsistency of wording in paragraph 27 of the Allegation, in that the medical term used referred to '*neurological*', whereas the witness statement of Dr V, the expert witness called by the GMC, referred to '*neurophysiological*'. The Tribunal brought this matter to the attention of the GMC and invited submissions as to whether the GMC wished to amend this paragraph of the Allegation. Mr Rigby, on behalf of the GMC, applied under Rule 17(6) of the Rules to amend paragraph 27 of the Allegation to substitute the word '*neurophysiological*' in place of '*neurological*'. He submitted that the application should be allowed as Dr Kidd had been given adequate notice of the hearing and had chosen not to attend. Further, there would be no injustice to Dr Kidd as the amendment would reflect the evidence of Dr V, which had been provided to Dr Kidd in advance of the hearing. The Tribunal allowed the amendment, having determined that it was in the interests of justice to do so. It concluded that Dr Kidd had received adequate notice of the proceedings, had chosen not to attend or to be represented, and also having noted that the amendment would be consistent with the

evidence already served in the case, which Dr Kidd had been provided with. It was satisfied that allowing the amendment would cause no prejudice to Dr Kidd.

The Allegation and the Doctor's Response

9. The Allegation made against Dr Kidd is as follows:

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

1. Between 2 March 2009 and 31 August 2022 you were employed as a Consultant Neurologist at the Royal Free London NHS Foundation Trust ('the Trust'). To be determined

2. Between 2 February 2013 and 30 June 2022 you held practising privileges at the Royal Free Private Patients Unit. To be determined

3. Between June 2019 and July 2020 you produced and/or contributed to the articles set out in Schedule 1, in which you stated an affiliation with the Institute of Immunity and Transplantation within University College London ('the Institute'). To be determined

4. You did not have an affiliation with the Institute. To be determined

5. You knew that you did not have an affiliation with the Institute. To be determined

6. Your actions at paragraph 3 were dishonest by reason of paragraphs 4 and 5. To be determined

Patient A

7. On or around 26 May 2021 you commenced Patient A on Cyclophosphamide treatment without obtaining the required approval from the Neuroimmunology Drugs and Therapeutics Committee ('NIDTC'). To be determined

8. On 16 June 2021 you emailed Ms L, Complaints Manager at the Trust, in relation to Patient A, and stated 'There has been a policy change and pharmacy decided that all patients had to stop treatment'. To be determined

9. On 30 June 2021 you wrote to Patient A's GP and stated 'You may have heard that we have had to stop Cyclophosphamide owing to a change in planning and programming at a managerial level, which has been a source of frustration to me'. To be determined

10. There had not been a policy change and/or change in planning and programming at a managerial level, in relation to the provision of Cyclophosphamide treatment. To be determined

11. You knew that there had not been a policy change and/or change in planning and programming at a managerial level, in relation to the provision of Cyclophosphamide treatment. To be determined

12. Your actions at paragraph 8 were dishonest by reason of paragraphs 10 and 11. To be determined

13. Your actions at paragraph 9 were dishonest by reason of paragraphs 10 and 11. To be determined

Patient B

14. On 7 July 2020 in an email to Ms M, you stated that Patient B had Chronic Inflammatory Demyelinating Polyneuropathy ('CIDP'). To be determined

15. Patient B did not have CIDP. To be determined

16. You knew or ought to have known that Patient B did not have CIDP. To be determined

17. Your actions at paragraph 14 were dishonest by reason of paragraphs 15 and 16. To be determined

18. On 19 January 2022 you attended a meeting with Dr N and Dr O, during which you stated that Dr P had told you that it was not necessary to seek the IvIg Panel's approval for Patient B's treatment with IvIg, because it was not necessary at that time, or words to that effect. To be determined

19. You knew that Dr P had not told you that it was not necessary to seek the IvIg Panel's approval for Patient B's treatment with IvIg. To be determined

20. Your actions at paragraph 18 were dishonest by reason of paragraph 19. To be determined

21. On 19 January 2021 you wrote to Dr Q, Consultant Neurologist, and stated that you had got funding for Patient B's IvIg through the IvIg Panel. To be determined

22. The IvIg Panel had not:

    a. discussed Patient B's case; To be determined

    b. approved funding for IvIg treatment for Patient B. To be determined

23. You knew that you had not had funding for Patient B's IvIg treatment approved by the IvIg Panel. To be determined

24. Your actions at paragraph 21 were dishonest by reason of paragraphs 22 and 23. To be determined

25. On 1 February 2022 you wrote to Patient B and her GP and stated that there was clear electrophysiological evidence for a small fibre neuropathy. To be determined

26. Patient B did not have any electrophysiological evidence for a small fibre neuropathy. To be determined

27. You knew that Patient B did not have any ~~neurological~~ neurophysiological evidence for a small fibre neuropathy. To be determined

28. Your actions at paragraph 25 were dishonest by reason of paragraphs 26 and 27. To be determined

Post-departure

29. Following your departure from the Trust you continued to access your Trust issued email account for correspondence relating to your work at the Trust, in contravention of the Trust's IT Acceptable Use Policy, on the dates listed in Schedule 2. To be determined

30. Following your departure from the Trust and the Royal Free Private Patients Unit on one or more occasion you continued to correspond with patients who were no longer under your care, regarding their medical conditions and/or treatment in that:

a. on 3 October 2022 you emailed Patient D via email, and provided her with information about the results of blood tests and a PET scan; To be determined

b. on 27 October 2022 you emailed Patient E's wife and advised that Patient ~~U~~E's treatment plan depended on the results of their upcoming scan, and asked them to provide you with the results of the scan; Amended under Rule 17(6), To be determined

c. on 30 October 2022 you emailed Patient F and advised them not to stop or reduce their MMF treatment, or words to that effect; To be determined

d. you provided Patient C with the results of an MRI scan via email; To be determined

e. on or around 13 September and 30 October 2022 you emailed Patient G and advised that you were trying to resume patient care from another location, or words to that effect; To be determined

f. on 1 September 2022 you:

i. consulted with Patient H by telephone; To be determined

ii. advised Patient H that you should keep in touch; To be determined

iii. advised Patient H that she should email you should there be any change to her condition, or words to that effect; To be determined

g. on 2 September 2022 you wrote to Patient H and her GP to confirm the consultation held on 1 September 2022; To be determined

h. in or around July 2023 you spoke with Dr R regarding Patient ~~J~~ I's treatment and made recommendations in relation to further specialist tests and potential changes in treatment. Amended under Rule 17(6), To be determined

31. On 4 November 2022 you emailed Dr N and stated that there had been no single circumstance in which you had given clinical advice to any patient who had contacted you following your departure from the Trust. To be determined

32. You knew that you had provided clinical advice to patients as set out at paragraphs 30a, c, d and f. To be determined

33. Your actions at paragraph 31 were dishonest by reasons of paragraphs 30a, c, d, f and 32. To be determined

34. Following your departure from the Trust and the Royal Free Private Patient Unit on one or more occasion you attempted to access medical records or information for patients you had previously treated in that on:

    a. 13 September 2022 you emailed Ms S, Administrator at the Trust, and asked her to send you a copy of MRI scan reports for Patient J; To be determined

    b. 20 September 2022 you emailed Ms S and asked her to send you copies of the letters you had produced regarding Patient K; To be determined

    c. 19 October 2022 and 30 October 2022 you emailed Ms S and asked her to send you the PET CT scan report for Patient D. 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 Facts to be Determined

10. Dr Kidd was not present or represented at these proceedings. He made no written admissions, but in an undated letter to the GMC regarding this hearing stated: *'The allegations in this case are essentially a manifestation of management irritation and misrepresentation'.* In light of this response, the Tribunal is required to determine the Allegation in its entirety.

Witness Evidence

11. The Tribunal received oral evidence on behalf of the GMC from Dr O, Consultant Neurologist and Clinical Lead for Neurosciences at the Trust, by video link on 24 February 2026. Their witness statement was dated 21 May 2024.

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

- Professor U, Director of the Institute of Immunity and Transplantation ('the Institute') and Clinical Academic within University College London ('UCL'). Their

witness statement was dated 15 March 2023, with supplemental witness statements dated 13 November 2025 and 26 February 2026, and an email response to questions from the Tribunal dated 2 March 2026;

- Dr R, Consultant Neurologist at NCA NHS Foundation Trust. Their witness statement was dated 20 December 2023;
- Dr Q, Consultant Neurologist at the Royal Free Hospital and National Hospital for Neurology and Neurosurgery. Their witness statement was dated 9 January 2024;
- Ms S, Overseas Eligibility Officer at the Royal Free Hospital and Administrator at the Trust at the time of the alleged events. Their witness statement was dated 7 February 2024;
- Dr N, Medical Oncologist at the Trust. Their witness statement was dated 18 April 2024. The Tribunal also received a document containing responses to Tribunal questions on 2 March 2026;
- Dr P, Consultant Rheumatologist at the Hospital. Their witness statement was dated 7 May 2024, with a supplemental witness statement dated 29 July 2024.

13. Dr Kidd did not provide a witness statement, but the Tribunal was provided with a Rule 7 response provided on behalf of Dr Kidd, dated 25 April 2025, and an undated letter from Dr Kidd to the GMC regarding this hearing.

Expert Witness Evidence

14. The Tribunal also received evidence from one expert witness, Dr V, Consultant Clinical Neurologist and Neurology Continuing Professional Development ('CPD') Assessor for the Royal College of Physicians. Dr V was called by the GMC and gave oral evidence on 25 February 2026. She also provided an expert report dated 30 July 2024.

15. Dr V's evidence was directed at assisting the Tribunal in understanding Dr Kidd's involvement in the care of each patient, the standard of care provided by Dr Kidd and the standard expected of a reasonably competent Consultant Neurologist.

Documentary Evidence

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

- *Neurosarcoidosis: clinical manifestations, investigation and treatment.* Practical Neurology 2020;20:199-212. Accepted 5 January 2020 (full article);
- *Relapse of severe neurosarcoidosis with switch from originator infliximab to biosimilar.* Neurology Journals 2020 Jun 2;94(22):991-993 (affiliation extract);

- *Sarcoidosis of the central nervous system: Safety and efficacy of treatment, and experience of biological therapies*. Clinical Neurology and Neurosurgery 2020 Jul;194:105811(affiliation extract);
- *Granulomatous CNS inflammation associated with seminoma.* Journal of Neurology 2019 Jun;266(6):1389-1393 (affiliation extract);
- Various correspondence relating to the care and treatment of relevant patients;
- Letters from Dr N to Dr T, Responsible Officer at the Trust, setting out the concerns raised in respect of Dr Kidd, dated 22 January 2022 and 2 November 2022;
- Trust investigation meeting with Dr N notes, dated 12 May 2022, and Dr P, dated 5 May 2022.

The Tribunal's Approach

17. In reaching its decision on the facts, the Tribunal will apply the civil standard of proof. This means that the Tribunal must decide whether, on the balance of probabilities, the GMC is able to prove it is more likely than not that the matters occurred as alleged. The burden of proof rests with the GMC and it is for the GMC to prove the case that it is presenting against the doctor. There is no burden on Dr Kidd to prove or disprove anything.

18. The Tribunal will approach fact finding by firstly identifying agreed facts and evidence. To reach a decision on the disputed facts, the Tribunal will assess the evidence in the round. It will consider what conclusions and inferences can be drawn from the documentary evidence. The Tribunal will then consider the available oral evidence and subject that evidence to critical scrutiny against the agreed facts and documentary evidence to consider a witness' reliability and credibility. The Tribunal should not decide reliability and credibility based on the demeanour of a witness alone.

19. The Tribunal took account of Dr Kidd's previous good character. It was submitted by the GMC and determined by the Tribunal his previous good character was solely relevant to the propensity limb in this case as Dr Kidd had not provided a witness statement or given evidence in the proceedings.

The Tribunal's Analysis of the Evidence and Findings

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

Paragraph 1

21. The Tribunal considered that the evidence within the bundle demonstrates that Dr Kidd was employed as a Consultant Neurologist at the Trust between 2 March 2009 and 31 August 2022. Further, this has not been disputed by Dr Kidd. It was of the view that this was factual and non-controversial.

22. Accordingly, the Tribunal found paragraph 1 of the Allegation proved.

Paragraph 2

23. The Tribunal considered that the evidence within the bundle, and in particular that of Dr N, was that Dr Kidd held practising privileges at the Unit between 2 February 2013 and 30 June 2022. Further, this has not been disputed by Dr Kidd. It was of the view that this was factual and non-controversial.

24. Accordingly, the Tribunal found paragraph 2 of the Allegation proved.

Paragraph 3

25. The Tribunal has been provided with copies of the articles set out in Schedule 1. It noted that all of the articles clearly state at the outset an affiliation with the Institute of Immunity and Transplantation within UCL and were authored or contributed to by Dr Kidd. The Tribunal was satisfied on those grounds that Dr Kidd had produced the articles, and that he had claimed an affiliation with the Institute of Immunity and Transplantation within UCL.

26. Accordingly, the Tribunal found paragraph 23 of the Allegation proved.

Paragraph 4

27. The Tribunal took into account the evidence of Professor U. Professor U stated in his witness statement that Dr Kidd did not have an affiliation with the Institute of Immunity and Transplantation. Professor U explained that he had investigated and found that Dr Kidd had an honorary contract with a different department at UCL.

28. Accordingly, the Tribunal found paragraph 4 of the Allegation proved.

Paragraph 5

29. The Tribunal took into account that Dr Kidd was an experienced doctor and academic within Neurology. It noted Professor U's evidence that Dr Kidd had an affiliation to a different department at UCL. It noted that this evidence has not been challenged by Dr Kidd.

30. The Tribunal was of the view that, based on Dr Kidd's experience and his knowledge of UCL, it could be inferred that it was more likely than not that Dr Kidd knew that he did not have an affiliation with the Institute of Immunity and Transplantation at UCL.

31. Accordingly, the Tribunal found paragraph 5 of the Allegation proved.

Paragraph 6

32. The Tribunal went on to consider whether Dr Kidd's actions in claiming affiliation with the Institute of Immunity and Transplantation in the published articles were dishonest. It has already found that Dr Kidd knew that he did not have affiliation when he published the articles. It noted that Dr Kidd has not offered any explanation as to why he claimed affiliation when he did not have it. In the absence of any such explanation, the Tribunal found that his actions must have been dishonest by the standards of ordinary, decent people.

33. Accordingly, the Tribunal found paragraph 6 of the Allegation proved.

Patient A

Paragraph 7

34. The Tribunal noted that factually, the evidence from Dr V was that Patient A was first given Cyclophosphamide treatment on 26 May 2021, so that it could be satisfied that Dr Kidd commenced treatment on that date.

35. The Tribunal has been provided with a post-dated application to the NIDTC for Patient A to receive the Cyclophosphamide treatment in June 2021, which under the comments section states *'treatment arranged prior to change in funding arrangements. She is due third dose 9th June prior to meeting and so it is very important that she is not delayed unnecessarily pending confirmation of the treatment plan'.*

36. The Tribunal also took into account the statement of Dr N, in which she stated:

> *'I am unable to find a copy of the actual email sent to Dr Kidd. My recollection aligns with the content of the email – Dr Kidd acknowledged that the correct process had not been followed in that Patient A should have been discussed at the NDTC before her treatment commenced. I think Dr Kidd also said that he had not remembered the requirement to discuss such patients at the NDTC.'*

37. From this, the Tribunal accepted that Dr Kidd had commenced treatment for Patient A without prior approval, and he subsequently tried to remedy this with a post-dated application.

38. Accordingly, the Tribunal found paragraph 7 of the Allegation proved.

Paragraph 8

39. The Tribunal noted Dr N's evidence, in which she exhibited a copy of the email from Dr Kidd to the complaints manager, dated 16 June 2021, which states:

> *'There has been a policy change and pharmacy decided that all patients had to stop treatment'*

40. On that evidence, which is clear and not disputed, the Tribunal found paragraph 8 of the Allegation proved.

Paragraph 9

41. The Tribunal noted the evidence of Dr O, who exhibited a copy of the letter from Dr Kidd to Patient A's GP, dated 30 June 2021, which states:

> '*You may have heard that we have had to stop Cyclophosphamide owing to a change in planning and programming at a managerial level, which has been a source of frustration to me.'*

42. On that evidence, which is clear and not disputed, the Tribunal found paragraph 9 of the Allegation proved.

Paragraph 10

43. The Tribunal noted the evidence of Dr N, which was that Dr Kidd was aware of the NIDTC, having been involved in its establishment and that Dr Kidd may have contributed to the drafting of the terms of reference.

44. The Tribunal also heard evidence from Dr O that the NIDTC had been established approximately six months prior to Patient A receiving their first treatment, to provide clearer governance around the prescription of certain immunomodulatory drugs or treatments. The Tribunal noted that Dr O stated that, prior to the establishment of NIDTC, if a clinician sought to use toxic or high-cost drugs outside of a licenced indication, or where no relevant guidelines existed, individual requests would be submitted to and reviewed by a senior

manager such as the divisional director. Once the NIDTC was set up, requests for treatment such as Cyclophosphamide required approval through this panel, which had its own terms of reference.

45. The Tribunal concluded that this could be classed as a policy change within the department, albeit not a recent change.

46. With this in mind, the Tribunal was not satisfied that the GMC had discharged the burden of proof on the facts set out before it. On that basis, the Tribunal found paragraph 10 of the Allegation not proved.

Paragraph 11

47. Having found that there had been a change in policy and/or change in planning and programming at a managerial level, in relation to the provision of Cyclophosphamide treatment, the Tribunal could not find this paragraph of the Allegation proved.

48. Accordingly, the Tribunal found paragraph 11 of the Allegation not proved.

Paragraph 12

49. Having found paragraphs 10 and 11 of the Allegation not proved, the Tribunal decided that it followed that this paragraph of the Allegation was also not proved.

50. Accordingly, the Tribunal found paragraph 12 of the Allegation not proved.

Paragraph 13

51. Having found paragraphs 10 and 11 of the Allegation not proved, the Tribunal decided that it followed that this paragraph of the Allegation could not be established.

52. Accordingly, the Tribunal found paragraph 13 of the Allegation not proved.

Patient B

Paragraph 14

53. The Tribunal has been provided with a copy of the email from Dr Kidd to the neurology pharmacist, Ms M, dated 7 July 2020, which clearly states that Patient B had Chronic Inflammatory Demyelinating Polyneuropathy ('CIDP').

54. Accordingly, the Tribunal found paragraph 14 of the Allegation proved.

Paragraph 15

55. The Tribunal noted the evidence of Dr V, who stated that, having reviewed the medical notes of Patient B, there was no evidence that Patient B had CIDP, and subsequent tests suggested that she did not have this condition. Further, the only mention of CIDP as a diagnosis is on the request that Dr Kidd sent to the pharmacy for the treatment, it was not contained within any clinical notes or letters where one would expect a diagnosis to be recorded.

56. Therefore, the Tribunal found paragraph 15 of the Allegation proved.

Paragraph 16

57. The Tribunal heard evidence from Dr V that having normal electrophysiological studies, such as those in Patient B, would rule out a diagnosis of CIDP of the type that would respond to IVIG. The Tribunal noted that Dr Kidd is a highly experienced clinician and would have known from the investigation results he had access to, that CIDP had been ruled out as a diagnosis.

58. Therefore, the Tribunal was satisfied, on the balance of probabilities, that Dr Kidd did know that Patient B did not have CIDP. Accordingly, it found paragraph 16 of the Allegation proved.

Paragraph 17

59. Having found that Dr Kidd knew that Patient B did not have CIDP when he stated that she did, the Tribunal considered that, by the standards of ordinary, decent people, this was dishonest.

60. Accordingly, the Tribunal found paragraph 17 of the Allegation proved.

Paragraph 18

61. The Tribunal took into consideration the notes of the meeting between Dr N, Dr O and Dr Kidd, and that as part of the summary, it was stated that Dr Kidd had said:

> '*I discussed this case informally, [Dr P], the chair of the IVIg panel, who approved treatment. No formal application was made as this was not necessary at that time.'*

62. The Tribunal was satisfied that the meeting had taken place and that Dr Kidd had made the above statement.

63. Accordingly, the Tribunal found paragraph 18 of the Allegation proved.

Paragraph 19

64. The Tribunal noted that Dr P, in his evidence, could not specifically recall whether an informal discussion had taken place with Dr Kidd or not, in relation to Patient B, due to the passage of time. He said: '*I have no recollection of ever discussing Patient B with Dr Kidd but that does not necessarily mean that we did not discuss it'.*

65. In his supplementary witness statement, Dr P stated that it was not necessary for a discussion regarding a first or second dose of IVIG in some circumstances. The Tribunal would have liked the opportunity to put questions to Dr P, but was unable to do this due to his limited availability as he had not been given notice to attend as a witness by the GMC. The Tribunal was not prepared to delay proceedings to allow him to attend at a later date.

66. The Tribunal found that the GMC had not discharged the burden of proof in respect to this paragraph of the Allegation.

67. Accordingly, the Tribunal found paragraph 19 of the Allegation not proved.

Paragraph 20

68. Having found paragraph 19 of the Allegation not proved, the Tribunal decided that it followed that this paragraph of the Allegation could not be established.

69. Accordingly, the Tribunal found paragraph 20 of the Allegation not proved.

Paragraph 21

70. The Tribunal has been provided with a copy of the letter, dated 19 January 2021, from Dr Kidd to Dr Q, in which Dr Kidd stated that he had received funding for IVIG treatment for Patient B through the IVIG panel.

71. Accordingly, the Tribunal found paragraph 21 of the Allegation proved.

Paragraph 22(a) and (b)

72. The Tribunal noted that Dr P stated in his witness statement that Patient B was never discussed at the IVIG panel. It noted that there was only a record of a partially completed

application form in Patient B's name following requests from a pharmacist to complete this form. Dr P stated that, from reviewing the minutes of the IVIG panel, he found no reference to Patient B. As a result of this, the Tribunal concluded that it was unlikely that the application form had ever been submitted to the IVIG panel. On that basis, the Tribunal was satisfied that the IVIG panel had not discussed Patient B's case, and had not approved funding for Patient B.

73. Therefore, the Tribunal found paragraph 22(a) and (b) of the Allegation proved.

Paragraph 23

74. On the basis that the IVIG panel had not discussed Patient B, as Dr Kidd had not submitted her case to the IVIG panel, it was more likely than not that Dr Kidd knew that he did not have approved funding for her IVIG treatment.

75. Accordingly, the Tribunal found paragraph 23 of the Allegation proved.

Paragraph 24

76. Having found that Dr Kidd knew he did not have approved funding for the IVIG treatment for Patient B, the Tribunal was satisfied that it was dishonest for him to have made that claim in his letter of 19 January 2021.

77. Accordingly, the Tribunal found paragraph 24 of the Allegation proved.

Paragraph 25

78. The Tribunal has been provided with a copy of the letter, dated 1 February 2022, from Dr Kidd to Patient B and copied to her GP, in which it is stated '*there was clear electrophysiological evidence for a small fibre neuropathy*'.

79. Accordingly, the Tribunal found paragraph 25 of the Allegation proved.

Paragraph 26

80. The Tribunal accepted the expert evidence of Dr V, who stated that from her review of Patient B's medical notes there is no electrophysiological evidence for a small fibre neuropathy. The Tribunal also noted that Dr Kidd sent a letter to Patient B on 21 October 2019, in which he stated: '*the nerve conduction tests were normal including the thermal threshold… and that the spinal cord scan was fine*'.

81. Therefore, the Tribunal was satisfied that Patient B did not have any electrophysiological evidence for a small fibre neuropathy and found paragraph 26 of the Allegation proved.

Paragraph 27

82. The Tribunal noted that Dr Kidd is a highly experienced clinician. It considered the evidence of Dr V which shows that Dr Kidd ought to have known that there was no neurophysiological evidence for a small fibre neuropathy. Further, Dr V explained that Dr Kidd had received a letter from Patient B's GP, dated 11 March 2021, raising concerns about the diagnosis and the planned IVIG treatment.

83. Having found that Patient B did not have any neurophysiological evidence for a small fibre neuropathy, and in the context of Dr Kidd being a very experienced clinician, who had been questioned about his initial views, the Tribunal concluded that Dr Kidd knew that Patient B did not have any neurophysiological evidence for a small fibre neuropathy. Accordingly, it found paragraph 27 of the Allegation proved.

Paragraph 28

84. Having found that Dr Kidd knew that Patient B did not have any neurophysiological evidence for a small fibre neuropathy when he stated that she did, the Tribunal considered that by the standards of ordinary, decent people, this was dishonest.

85. Accordingly, the Tribunal found paragraph 28 of the Allegation proved.

Post-departure

Paragraph 29

86. The Tribunal has been provided with a copy of the Trust's IT Acceptable Use Policy and copies of the emails set out in Schedule 2.

87. The Tribunal noted that Dr Kidd had been using his NHS email address at a time when it was still attached to the Trust, after he had left his role and before his email address was transferred to his new employer. Further, it was used in relation to patients at the Trust. The Tribunal noted that the Trust's IT Acceptable Use Policy sets out what steps should be taken once a member of staff has left the Trust and/or transfers to another trust. Within this document, it states that '*former employees are not permitted to retain their Trust issued address unless they are still formally carrying out Trust activities, for example, research and an honorary contract is in place'.* The evidence before the Tribunal was that Dr Kidd did not

have any such arrangements in place after he left the Trust. The Tribunal also took into account the witness statement of Dr N, who stated that Dr Kidd should not have retained or had access to data belonging to the Trust and that it would have been Dr Kidd's responsibility to be aware of the content of and assure his compliance with the Trust's IT Acceptable Use Policy. The Tribunal determined that Dr Kidd should not have been using his Trust issued email address to correspond with or about patients at the Trust.

88. The Tribunal concluded that Dr Kidd's actions amounted to a contravention of the Trust's IT Acceptable Use Policy.

89. Accordingly, the Tribunal found paragraph 29 of the Allegation proved.

Paragraph 30 (a), (b), (c), (d), (e), (f), (g) and (h)

90. The Tribunal considered the documentary evidence of the emails, letters and consultations that it has been provided with. The evidence shows that:

a) On 3 October 2022, Dr Kidd emailed Patient D and provided her with information about the results of blood tests and a PET scan;
b) On 27 October 2022, Dr Kidd emailed Patient E's wife and advised that Patient E's treatment plan depended on the results of their upcoming scan, and asked them to provide him with the results of the scan;
c) On 30 October 2022, Dr Kidd emailed Patient F and advised them not to stop or reduce their MMF treatment;
d) In a complaint letter to the Trust, dated 16 February 2023, Patient C said that Dr Kidd provided her with the results of an MRI scan;
e) In a complaint letter to the Trust, Patient G said that, on 13 September 2022 and 30 October 2022, Dr Kidd wrote to Patient G and advised that he was trying to resume patient care from another location;
f) Dr Kidd wrote a clinic letter dated 2 September 2022, which indicates that on 1 September 2022:
    i) Dr Kidd consulted with Patient H by telephone
    ii) He subsequently advised Patient H to keep in touch
    iii) He advised her that she should email him should there be any change to her condition.
g) On 2 September 2022, Dr Kidd wrote to Patient H and her GP to confirm the consultation held on 1 September 2022. The Tribunal has considered Dr Kidd's representations stating that it was more than likely this correspondence was sent by administrative staff 'mopping up' outstanding dictations after his departure. However,

the Tribunal noted that the consultation took place on 1 September 2022, a day after Dr Kidd left the Trust.

h) Dr R stated in his witness statement to the GMC that, in early July 2023, Dr Kidd spoke with him regarding Patient I's treatment and made recommendations in relation to further specialist tests and potential changes in treatment.

91. Consequently, the Tribunal concluded that, following Dr Kidd's departure from the Trust and the Unit, on one or more occasions, he continued to enter into correspondence with patients who were no longer under his care regarding their conditions and/or treatment.

92. Accordingly, the Tribunal was satisfied that paragraph 30 of the Allegation was proved in its entirety.

Paragraph 31

93. The Tribunal has taken into account the witness statement of Dr N, in which she exhibits the email of 4 November 2022. The Tribunal noted that this email was from Dr Kidd to Dr N and that Dr Kidd stated: '*there has been no single circumstance in which I have given clinical advice to any patient who had contacted me*'.

94. Accordingly, the Tribunal found paragraph 31 of the Allegation proved.

Paragraph 32

95. The Tribunal reviewed the evidence as relates to paragraphs 30(a), (c), (d) and (f). It noted that: Dr Kidd had given advice to Patient D in relation to their blood test results (30(a)); there is email evidence to show that Dr Kidd advised Patient F not to stop or reduce treatment (30(c)); that Patient C stated in their complaint to the Trust that they had obtained their MRI scan results from Dr Kidd (30(d)); and that in relation to Patient H, Dr Kidd had undertaken a telephone consultation, had advised the patient to keep in touch and to let them know if there was a change in their condition (30(f)). The Tribunal determined that this could all be interpreted as giving clinical advice and that Dr Kidd, as an experienced clinician would have known that this would be considered as giving clinical advice.

96. Accordingly, the Tribunal found paragraph 32 of the Allegation proved.

Paragraph 33

97. Having found that Dr Kidd knew that he had given clinical advice to some patients at the Hospital after leaving the Trust, the Tribunal concluded that his statement that he had not, was dishonest by the standards of ordinary, decent people.

98. Accordingly, the Tribunal found paragraph 33 of the Allegation proved.

Paragraph 34

99. The Tribunal noted that Dr Kidd formally left the Trust's employment on 31 August 2022 and that he left the Unit on 30 June 2022. However, there is clear evidence that Dr Kidd corresponded with, and about, patients who were still under the Trust's care after his employment had ended.

Paragraph 34(a)

100. The Tribunal considered the witness statement of Ms S, in which she stated that she was contacted by Dr Kidd after he left the Trust asking to be supplied with information about various patients. In relation to Patient J, the Tribunal has been provided with a copy of an email from Dr Kidd to Ms S, dated 13 September 2022, in which he requested Patient J's MRI scan results.

101. Accordingly, the Tribunal found paragraph 34(a) of the Allegation proved.

Paragraph 34(b)

102. The Tribunal considered the evidence of Ms S, in which she stated that Dr Kidd sent her an email, dated 20 September 2022, a copy of which was provided to the Tribunal, in which Dr Kidd requested letters in relation to his former private patient, Patient K.

103. Accordingly, the Tribunal found paragraph 34(b) of the Allegation proved.

Paragraph 34(c)

104. The Tribunal has noted that, in the witness statement of Ms S, she stated that, between 19 October 2022 and 2 November 2022, she received an email and forwarded correspondence in relation to Patient D. The Tribunal has seen the relevant emails and noted that on 19 October 2022, Dr Kidd asked Ms S to send him Patient D's PET CT report, which he chased again on 30 October 2022.

105. Accordingly, the Tribunal found paragraph 34(c) of the Allegation proved.

The Tribunal's Overall Determination on the Facts

106. The Tribunal has determined the facts as follows:

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

1. Between 2 March 2009 and 31 August 2022 you were employed as a Consultant Neurologist at the Royal Free London NHS Foundation Trust ('the Trust'). **Determined and found proved.**

2. Between 2 February 2013 and 30 June 2022 you held practising privileges at the Royal Free Private Patients Unit. **Determined and found proved.**

3. Between June 2019 and July 2020 you produced and/or contributed to the articles set out in Schedule 1, in which you stated an affiliation with the Institute of Immunity and Transplantation within University College London ('the Institute'). **Determined and found proved.**

4. You did not have an affiliation with the Institute. **Determined and found proved.**

5. You knew that you did not have an affiliation with the Institute. **Determined and found proved.**

6. Your actions at paragraph 3 were dishonest by reason of paragraphs 4 and 5. **Determined and found proved.**

Patient A

7. On or around 26 May 2021 you commenced Patient A on Cyclophosphamide treatment without obtaining the required approval from the Neuroimmunology Drugs and Therapeutics Committee ('NIDTC'). **Determined and found proved.**

8. On 16 June 2021 you emailed Ms L, Complaints Manager at the Trust, in relation to Patient A, and stated 'There has been a policy change and pharmacy decided that all patients had to stop treatment'. **Determined and found proved.**

9. On 30 June 2021 you wrote to Patient A's GP and stated 'You may have heard that we have had to stop Cyclophosphamide owing to a change in planning

and programming at a managerial level, which has been a source of frustration to me'. **Determined and found proved.**

10. There had not been a policy change and/or change in planning and programming at a managerial level, in relation to the provision of Cyclophosphamide treatment. **Not proved.**

11. You knew that there had not been a policy change and/or change in planning and programming at a managerial level, in relation to the provision of Cyclophosphamide treatment. **Not proved.**

12. Your actions at paragraph 8 were dishonest by reason of paragraphs 10 and 11. **Not proved.**

13. Your actions at paragraph 9 were dishonest by reason of paragraphs 10 and 11. **Not proved.**

Patient B

14. On 7 July 2020 in an email to Ms M, you stated that Patient B had Chronic Inflammatory Demyelinating Polyneuropathy ('CIDP'). **Determined and found proved.**

15. Patient B did not have CIDP. **Determined and found proved.**

16. You knew or ought to have known that Patient B did not have CIDP. **Determined and found proved.**

17. Your actions at paragraph 14 were dishonest by reason of paragraphs 15 and 16. **Determined and found proved.**

18. On 19 January 2022 you attended a meeting with Dr N and Dr O, during which you stated that Dr P had told you that it was not necessary to seek the IvIg Panel's approval for Patient B's treatment with IvIg, because it was not necessary at that time, or words to that effect. **Determined and found proved.**

19. You knew that Dr P had not told you that it was not necessary to seek the IvIg Panel's approval for Patient B's treatment with IvIg. **Not proved.**

20. Your actions at paragraph 18 were dishonest by reason of paragraph 19. **Not proved.**

21. On 19 January 2021 you wrote to Dr Q, Consultant Neurologist, and stated that you had got funding for Patient B's IvIg through the IvIg Panel. **Determined and found proved.**

22. The IvIg Panel had not:

    a. discussed Patient B's case; **Determined and found proved.**

    b. approved funding for IvIg treatment for Patient B. **Determined and found proved.**

23. You knew that you had not had funding for Patient B's IvIg treatment approved by the IvIg Panel. **Determined and found proved.**

24. Your actions at paragraph 21 were dishonest by reason of paragraphs 22 and 23. **Determined and found proved.**

25. On 1 February 2022 you wrote to Patient B and her GP and stated that there was clear electrophysiological evidence for a small fibre neuropathy. **Determined and found proved.**

26. Patient B did not have any electrophysiological evidence for a small fibre neuropathy. **Determined and found proved.**

27. You knew that Patient B did not have any ~~neurological~~ neurophysiological evidence for a small fibre neuropathy**. Amended under Rule 17(6), Determined and found proved.**

28. Your actions at paragraph 25 were dishonest by reason of paragraphs 26 and 27. **Determined and found proved.**

Post-departure

29. Following your departure from the Trust you continued to access your Trust issued email account for correspondence relating to your work at the Trust, in contravention of the Trust's IT Acceptable Use Policy, on the dates listed in Schedule 2. **Determined and found proved.**

30. Following your departure from the Trust and the Royal Free Private Patients Unit on one or more occasion you continued to correspond with patients who were no longer under your care, regarding their medical conditions and/or treatment in that:

a. on 3 October 2022 you emailed Patient D via email, and provided her with information about the results of blood tests and a PET scan; **Determined and found proved.**

b. on 27 October 2022 you emailed Patient E's wife and advised that Patient ~~U~~E's treatment plan depended on the results of their upcoming scan, and asked them to provide you with the results of the scan; **Amended under Rule 17(6), Determined and found proved.**

c. on 30 October 2022 you emailed Patient F and advised them not to stop or reduce their MMF treatment, or words to that effect; **Determined and found proved.**

d. you provided Patient C with the results of an MRI scan via email; **Determined and found proved.**

e. on or around 13 September and 30 October 2022 you emailed Patient G and advised that you were trying to resume patient care from another location, or words to that effect; **Determined and found proved.**

f. on 1 September 2022 you:

   i. consulted with Patient H by telephone; **Determined and found proved.**

   ii. advised Patient H that you should keep in touch; **Determined and found proved.**

   iii. advised Patient H that she should email you should there be any change to her condition, or words to that effect; **Determined and found proved.**

g. on 2 September 2022 you wrote to Patient H and her GP to confirm the consultation held on 1 September 2022; **Determined and found proved.**

h. in or around July 2023 you spoke with Dr R regarding Patient ~~J~~ I's treatment and made recommendations in relation to further specialist tests and potential changes in treatment. **Amended under Rule 17(6), Determined and found proved.**

31. On 4 November 2022 you emailed Dr N and stated that there had been no single circumstance in which you had given clinical advice to any patient who had contacted you following your departure from the Trust. **Determined and found proved**

32. You knew that you had provided clinical advice to patients as set out at paragraphs 30a, c, d and f. **Determined and found proved**

33. Your actions at paragraph 31 were dishonest by reasons of paragraphs 30a, c, d, f and 32. **Determined and found proved**

34. Following your departure from the Trust and the Royal Free Private Patient Unit on one or more occasion you attempted to access medical records or information for patients you had previously treated in that on:

    a. 13 September 2022 you emailed Ms S, Administrator at the Trust, and asked her to send you a copy of MRI scan reports for Patient J; **Determined and found proved**

    b. 20 September 2022 you emailed Ms S and asked her to send you copies of the letters you had produced regarding Patient K; **Determined and found proved**

    c. 19 October 2022 and 30 October 2022 you emailed Ms S and asked her to send you the PET CT scan report for Patient D. **Determined and found proved**

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

Determination on Impairment - 12/03/2026

1. This determination was handed down in public. However, the Tribunal exercised its powers under Rule 41 of the Rules, to sit in private when the matters under consideration were confidential.

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

The evidence

3. The Tribunal has reviewed its findings of fact based on the evidence, and received a document from the GMC containing written responses to Tribunal questions from Dr Q. The questions were sent to Dr Q in advance of the Tribunal commencing its deliberation on the facts, but the response was not received until after the Tribunal announced its decision. The Tribunal considered that the responses may have some relevance to the workplace context at the Trust, when deliberating on impairment.

Submissions

4. On behalf of the GMC, Mr Rigby submitted that there were sufficient grounds established for the Tribunal to conclude that Dr Kidd's fitness to practice is impaired by reason of misconduct. Within his submissions, he referred the Tribunal to the principles set out in *Good Medical Practice* (2013) ('GMP'), relevant caselaw and to the *MPTS Guidance for Tribunals* ('the MPTS Guidance') (*MPT Hearings > Part B: Stage two - Impairment > Steps 2(a) to (e)).*

5. Mr Rigby submitted that impairment was established on the legal basis of misconduct. He submitted that, having established the legal basis, the Tribunal should go on to consider where on the spectrum of seriousness Dr Kidd's actions lie, taking into consideration steps 2(b) to (e) as set out in the MPTS Guidance. Mr Rigby reminded the Tribunal that, whilst it was possible for a dishonest doctor's fitness to practise not to be impaired, it would be very rare given that honesty is a fundamental tenet of medical practice. He also directed the Tribunal to consider aggravating factors as set out by the guidance, including repetitive behaviour, premeditated behaviour, undermining collaborative working and attempting to hide or avoid taking responsibility for behaviour.

6. Mr Rigby submitted that each of the findings against Dr Kidd, where they amount to dishonesty amount to misconduct at the high end of the spectrum of seriousness, such that his fitness to practise is impaired. He submitted that the number of such findings demonstrate a pattern of misconduct.

7. In relation to Dr Kidd's dishonesty regarding affiliation to the Institute, Mr Rigby submitted that his misconduct was clearly deliberate and repeated, although arguably there was little for Dr Kidd to gain. He submitted that Dr Kidd's actions clearly breached GMP at paragraphs 1, 65, 68 and 71, and was at the higher end of the seriousness spectrum. He stated that Dr Kidd has offered no explanation for his misconduct and has therefore not demonstrated insight. Further, there has been no remediation and there must remain a risk

of repetition. He submitted that the public and the profession would expect the Tribunal to find Dr Kidd's fitness to practise impaired under the principles of public protection.

8. In relation to Patient A, Mr Rigby submitted that Dr Kidd was in breach of paragraph 22 and 35 of GMP. He stated that this misconduct, whilst not so obviously serious as the dishonesty found elsewhere by the Tribunal, did amount to serious misconduct. He submitted that Dr Kidd had failed to provide an explanation for this misconduct and to show insight or remediation. Further, when taken together with the other misconduct, it was such that members of the public and/or colleagues would expect a finding of impairment.

9. Mr Rigby submitted that the misconduct in relation Patient B, particularly the dishonest conduct, shows a pattern of deliberate misconduct, repeated over a long period, which could have had an adverse effect upon the patient by reason of the misdiagnoses clearly identified by Dr V. He submitted that this was deliberate, repeated behaviour in breach of GMP, and was serious misconduct at the higher end of the spectrum. He stated that Dr Kidd has provided no explanation for his misconduct, nor has he shown any insight or remediation such that the risk of repetition remains. He submitted that the public and the medical profession would expect the Tribunal to make a finding of impairment.

10. In relation to Dr Kidd's post-departure conduct, Mr Rigby submitted that these amount to a deliberate act of dishonesty within a now established pattern of misconduct. He submitted that these actions were a breach of GMP and can be placed at the higher end of the spectrum of dishonesty. He submitted that Dr Kidd has not commented upon these allegations but through his solicitors, provided context for his communications at 30(a) to (h), there was no explanation or any demonstration of insight or remediation for his untruthfulness and dishonesty. He submitted that the public and the medical profession would expect the Tribunal to find Dr Kidd's fitness to practise impaired.

11. Mr Rigby concluded that the Tribunal should find that Dr Kidd's fitness to practise impaired by reason of the individual findings of serious misconduct.

The relevant legal principles

12. There is no burden or standard of proof at this stage of the proceedings and the decision of impairment is a matter for the Tribunal's judgment alone. The Tribunal will only make a finding of impairment where there is a legal basis for doing so and where a decision is reached that Dr Kidd poses a current and ongoing risk to one or more of the three parts of public protection which is likely to require restrictive action in response. The three parts of public protection are to protect, promote and maintain the health, safety and well-being of

the public; to promote and maintain public confidence in the profession; and to promote and maintain proper professional standards and conduct for members of the profession.

13. In approaching its 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, poses a current and ongoing risk to public protection requiring restrictive action in response and therefore could lead to a finding of impairment.

14. To assess whether Dr Kidd poses any current and ongoing risk to public protection which may require restrictive action in response, the Tribunal will consider:

- where on the spectrum of seriousness the allegation lies, based on the facts found proved;
- the impact of any relevant context known about Dr Kidd and/or their working environment, and
- how Dr Kidd has responded to the allegations.

The Tribunal's determination on impairment

15. The Tribunal first has to decide whether there is a legal basis for considering impairment.

16. The GMC has put forward the legal basis for considering impairment in this case as Misconduct.

Misconduct

17. Where the category of impairment is Misconduct, there is a two-stage test:

- whether the findings amount to misconduct?
- if so, whether the misconduct is serious

18. In *Roylance v GMC* [2000] 1AC 311, Lord Clyde, giving the judgment of the Privy Council, observed that misconduct involved acts or omissions which fell short of what was proper in the circumstances and that the standard of propriety might often be found by reference to the rules and standards normally required to be followed.

19. The Tribunal considered whether the facts found proved constituted a sufficiently serious departure from the standards of conduct reasonably expected of Dr Kidd, as a registered medical practitioner so as to amount to serious misconduct. It was assisted in the assessment of seriousness which has been developed in caselaw relating to Misconduct: The

test of serious misconduct has been described as conduct which would be regarded as deplorable by fellow practitioners or properly informed members of the public as stated in *General Medical Council v Meadow* [2006] EWCA Civ 1390. In that judgment they went on to quote: It must be serious and must be linked to the profession of medicine. He pointed out that conduct removed from the practice of medicine might qualify if it was of a sufficiently immoral or outrageous or disgraceful character. This was because the public reputation of, and public confidence in, the profession could be adversely affected.

20. The Tribunal was also assisted by the MPTS Guidance when assessing seriousness. The MPTS Guidance deals with some specific case types. In this case two specific case types are relevant: dishonesty and clinical concerns.

Affiliation

21. The Tribunal first considered misconduct in relation to Dr Kidd's dishonesty relating to his claims of affiliation when publishing the articles set out in Schedule 1. It had regard to paragraphs 1, 65 and 66 of GMP:

> *'1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.*
>
> *…*
>
> *65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*
>
> *66 You must always be honest about your experience, qualifications and current role.'*

22. The Tribunal also considered the MPTS Guidance *(Guidance introduction > Protecting the public in specific case types > Case type 2: dishonesty)* at paragraph 87 which sets out:

> *'Whilst a range of behaviour can be seen, the nature of the departure from the standards expected may mean that a concern or allegation relating to dishonesty falls at the high end of the spectrum of seriousness. Even a single incident of dishonesty can have a significant impact and pose a risk to public protection.'*

23. The Tribunal concluded that Dr Kidd's conduct had breached GMP, as the public are entitled to trust that doctors are being honest and accurate about their credentials and affiliations when publishing articles linked to their professional work.

24. The Tribunal considered the features that can affect seriousness. It observed that the dishonesty in relation to this was not a momentary or temporary lapse, but was persistent and repeated in that the affiliation stated was repeated in at least four different articles. It was of the view that Dr Kidd's actions had the potential to damage public trust and confidence in the profession and to undermine professional standards.

25. Taking into account all the evidence before it, the Tribunal determined that Dr Kidd's behaviour was a serious departure from the principles and fell seriously below the standards expected as set out in GMP and that it amounted to serious misconduct.

Patient A

26. In relation to Patient A, the Tribunal noted that it did not find dishonesty in relation to Dr Kidd's actions, but it did find that he had prescribed Cyclophosphamide treatment without approval from the NIDTC.

27. The Tribunal had regard to paragraph 22 of GMP, which provides:

> *'22 You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:*
>
> *a ...'*

28. The Tribunal noted the evidence of Dr V, who stated that the treatment for Patient A was appropriate in this case. Dr Kidd also acknowledged that he had made a mistake in failing to seek approval before commencing the treatment and had tried to rectify that error.

29. The Tribunal recognised that approval should have been sought, and that starting the treatment without the necessary approval was below the expected standard of a reasonably competent doctor and breached a principle set out in GMP. However, it was not satisfied that Dr Kidd's actions were so far below the expected standard that it amounted to serious misconduct, given that the treatment was appropriate and clinically indicated.

Patient B

30. In relation to Patient B, the Tribunal noted that there were several instances of dishonesty, including inaccurate diagnoses, and being dishonest about the approval of funding for the proposed treatment.

31. The Tribunal had regard to paragraphs 1 and 65 of GMP, as set out above. It also had regard to paragraph 71, which provides:

> *'71 You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.*
>
> *a You must take reasonable steps to check the information is correct.*
>
> *b You must not deliberately leave out relevant information.'*

32. The Tribunal also had regard to the MPTS Guidance (*Guidance introduction > Protecting the public in specific case types > Case type 2: dishonesty)*, in particular paragraph 87, and reminded itself that concerns or allegations relating to dishonesty fall at the higher end of the spectrum of seriousness.

33. The Tribunal observed that the dishonesty in relation to Patient B was not a momentary or temporary lapse, but was persistent and repeated in that untruthful statements were made in relation to Patient B on 7 July 2020, 19 January 2021 and 1 February 2022. The Tribunal concluded that Dr Kidd's actions had the potential to damage public trust and confidence in the medical profession and to undermine professional standards.

34. The Tribunal also had regard to the MPTS Guidance (*Guidance introduction > Protecting the public in specific case types > Case type 5: clinical concerns)* at paragraphs 151, 153, 154, 155, 157, 160, 162 and 164 provides:

> *'151 Clinical concerns usually arise in a doctor's working life. Clinical concerns usually arise in a doctor's working life. A clinical concern describes behaviour or poor performance relating to a doctor's clinical practice or how they discharge a specific role for which they require or use their clinical knowledge, skills or experience. This includes a wide range of activities such as delivering patient care, acting as a clinical lead, …*

…

153 *Whether the doctor's performance or behaviour amounts to a clinical concern will be judged by considering whether there has been a departure from the professional standards and if so, the extent of that departure.*

154 *A clinical concern can incorporate a wide range of activities or omissions, and the doctor's poor performance or behaviour may be directed towards or impact patients, relatives of patients or colleagues. (Colleagues include anyone a doctor works with, whether or not they are doctors).*

155 *Good doctors make the care of patients their first concern, work effectively with colleagues, provide a good standard of practice and care and are open and honest when things go wrong. They work within their competence, keep their knowledge and skills up to date and demonstrate leadership within their role.*

…

157 *To develop and maintain effective teamworking and interpersonal relationships, doctors must listen to colleagues, communicate clearly, politely and considerately, recognise and show respect for colleagues' skills and contributions and work collaboratively.*

…

160 *Doctors should be familiar with and use, the clinical governance and risk management structures and processes in the organisation where they work or are contracted to. They must act promptly if they think patient safety or dignity is, or maybe, seriously compromised and be open and honest with patients if things go wrong…*

…

162 *Doctors must be competent in all aspects of their work, including where applicable, formal leadership roles, management, research and teaching. They must recognise and work within the limits of their competence and keep up to date with guidelines and developments that affect their work.*

...

164 *Clinical concerns can include a wide range of matters relating to a doctor's behaviour and/or performance at work. A view will need to be reached about where on the spectrum of seriousness the concern or allegation lies with reference to the nature and extent of the departure from the professional standards and considering the presence of any features that increase seriousness. An expert opinion may be available to assist with this depending on the stage of the fitness to practise process the matter has reached.'*

35. The Tribunal reminded itself of all of the findings made at the fact-finding stage including its findings that Dr Kidd had failed to follow well-established guidelines and clinical governance arrangements designed to ensure patient safety, had made inaccurate records giving a misdiagnosis for a patient, and that he had been dishonest in his communication with colleagues. Further, the Tribunal found that, on occasion, Dr Kidd's communication in relation to Patient B lacked professionalism. On 1 February 2022, Dr Kidd wrote to Patient B expressing his disappointment that it had not been possible for any neurologist at Lister Hospital to take over her care and to find a different neurologist in Bedfordshire. He stated there is disagreement about the diagnosis, that it was up to her to '*choose whom you believe*'.

36. Taking into account all the evidence before it, the Tribunal determined that Dr Kidd's behaviour was a serious departure from the principles set out in GMP and fell seriously below the standards expected of a doctor. The Tribunal concluded that his conduct in relation to Patient B amounted to serious misconduct.

Post-departure concerns

37. In relation to the post-departure concerns, the Tribunal noted that there were several instances of providing medical advice to patients and that those occurred between September and November 2022, when he should not have done this as he had left the Trust by this stage.

38. The Tribunal had regard to paragraphs 12, 19, 20 and 44 of GMP:

'12 *You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.*

…

19 *Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.*

20 *You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection law requirements.*

…

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

a share all relevant information with colleagues involved in your patients' care within and outside the team, …

b …'

39. The Tribunal also had regard to the MPTS Guidance *(Guidance introduction > Protecting the public in specific case types > Case type 2: dishonesty)* particularly at paragraphs 158 and 159:

'158 *Doctors must contribute to the continuity of patient care…*

159 *Documents that doctors make to formally record their work, including patient records, must be clear, accurate contemporaneous and legible.'*

40. In relation to Dr Kidd communicating with patients after his departure from the Trust, the Tribunal had regard Paragraph 158 of MPTS Guidance (*Guidance introduction > Protecting the public in specific case types > Case type 5: clinical concerns)* which provides that doctors must contribute to the continuity of patient care. The Tribunal noted, with some concern, the tone and content of Dr Kidd's communication with his former patients. The communication did not always reflect favourably on his colleagues or the Trust. The communication displayed a lack of professionalism at times:

'*As I think you know I can't see you at present although we are trying to fix up the new clinic so I am keen that neither you nor any one else who doesn't understand your condition reduces your teratment* [sic]'

41. Dr Kidd should not have been communicating with his former patients at the Trust as this was in breach of the Trust's IT Acceptable Use Policy. Further, by providing clinical advice to patients that he was no longer responsible for, this had the potential to place these patients at risk, given that those at the Trust responsible for their care were unaware of the information and advice being given.

42. In relation to the dishonesty in relation to Dr Kidd's post-departure actions, the Tribunal determined it was not a momentary or temporary lapse but was deliberate in that he knew he had given clinical advice to patients on more than one occasion. It was of the view that Dr Kidd's actions would damage public trust in the medical profession and undermine professional standards. Further, it risked patient safety, because as noted above Dr Kidd had contacted patients without the knowledge of the Trust, who had responsibility for the care of those patients.

43. Further, Dr Kidd did not appropriately document the contact he had with some of those former patients, thereby jeopardising the continuity of patient care and treatment.

44. Taking into account all the evidence before it, the Tribunal determined that Dr Kidd's behaviour was a serious departure from the principles set out in GMP and fell seriously below the standards expected such that it amounted to serious misconduct.

Impairment

Is there a legal basis for considering impairment?

45. Having found that the facts found proved amount to serious misconduct, the Tribunal went on to consider whether, as a result of that serious misconduct, Dr Kidd's fitness to practice is currently impaired. The Tribunal was satisfied, having found Dr Kidd's actions amounted to serious misconduct, that there was a legal basis for a finding of impairment.

46. The Tribunal had regard to paragraph 6 of the MPTS Guidance which states,

'6 Where there is a legal basis for considering a doctor's fitness to practise, to assess whether that doctor poses any current and ongoing risk to public protection, an MPT will consider:

- *the seriousness of the facts found proved,*
- *any relevant context known about the doctor and/or their working environment, and*
- *how the doctor has responded to the allegation(s).'*

47. The Tribunal considered each of these three steps in turn (Steps 2(b) to 2(d) in the MPTS Guidance).

Where on the spectrum of seriousness does the allegation lie?

48. At this stage the Tribunal:

- identified the starting point for assessing seriousness
- identified any features that increase seriousness
- confirmed where on the spectrum of seriousness the allegation is (that is lower end, mid-range or higher end) and therefore determine the starting point for assessing risk (is it low, medium or high).

49. The Tribunal considered the starting point for assessing seriousness. It appreciated that all allegations where a finding that the legal basis of misconduct is established are serious but that, within the range of these matters, some allegations will be more serious than others and the Tribunal's assessment of seriousness must reflect the individual circumstances of this case.

50. The Tribunal had regard to the MPTS Guidance, including the comment made within *Guidance introduction > Protecting the public in specific case types > Case type 2: dishonesty* as to seriousness in dishonesty cases:

> *'87 Whilst a range of behaviour can be seen, the nature of the departure from the standards expected may mean that a concern or allegation relating to dishonesty falls at the high end of the spectrum of seriousness. Even a single incident of dishonesty can have a significant harmful impact and pose a risk to public protection.'*

51. The Tribunal also had regard to the MPTS Guidance (*Guidance introduction > Protecting the public in specific case types > Case type 5: clinical concerns),* particularly at paragraph 164 as set out above.

52. Additionally, the Tribunal took into consideration *MPT Hearings > Part B: Stage two - Impairment* of the MPTS Guidance, which included that:

'28 Allegations that usually fall at the lower end of the spectrum of seriousness and due to their nature are more likely to be easily remediable include, but are not limited to:

…

an incident of dishonest behaviour which is limited in nature and had limited impact, such as where it occurred outside of the doctor's professional role and the value of any financial or other benefit derived was low…

…

31 Allegations that are likely to fall at the higher end of the spectrum of seriousness include, but are not limited to:

…

dishonesty, other than where it occurred outside of the doctor's professional role and was not persistent or repeated, and the value or other benefit derived was not significant…'

53. In considering the starting point the Tribunal had regard to its findings and the nature of the allegation, particularly as the dishonesty was carried out whilst Dr Kidd was acting in a professional role and involved several episodes of dishonesty which persisted over time. The Tribunal was of the view that the allegation in this case lies at the higher end of the spectrum of seriousness.

54. Having taken these factors into account and taking into account the MPTS Guidance as set out above, the Tribunal decided that the starting point for assessing seriousness in this case was at the higher end of the spectrum of seriousness.

55. The Tribunal next considered whether there were any features which may increase the seriousness of the allegation such that it moves up the spectrum of seriousness. It had regard to the non-exhaustive list of such features set out at paragraph 36 of the MPTS Guidance (*MPT Hearings > Part B: Stage two - Impairment)* and considered that the following applied:

- The behaviour was persistent and continued over a prolonged period of time;

- The behaviour involved elements of premeditation, particularly in respect to Patient B;
- A reckless disregard for patient safety or professional standards;
- The behaviour undermined a system designed to protect the public; and
- The behaviour undermined collaborative working.

56. The Tribunal found that Dr Kidd had shown a reckless disregard for professional standards which persisted over a period of time.

57. Having decided that the misconduct is at the higher end of the spectrum of seriousness, the Tribunal concluded therefore that the starting point for assessing current and ongoing risk to public protection is high.

58. The Tribunal had regard to the MPTS Guidance (*Guidance introduction > Protecting the public in specific case types > Case type 2: dishonesty)* at paragraphs 90 and 91, which provide:

> *'90 Many allegations relating to dishonesty fall at the higher end of the spectrum of seriousness. Where they do, the starting point for assessing current and ongoing risk to public protection will be high.*
>
> *91 In these cases, evidence of relevant context known about the doctor and/or their working environment and evidence of insight and remediation that decrease risk may have less impact because dishonesty allegations falling at the higher end of the spectrum of seriousness can be more difficult to remediate.'*

59. The Tribunal had regard to the MPTS Guidance (*Guidance introduction > Protecting the public in specific case types > Case type 5: clinical concerns) at paragraphs* 168 to 170:

> *'168 Allegations relating to clinical concerns can fall at the lower, mid-range or higher end of the spectrum of seriousness depending on the circumstances of the case. This means the starting point for assessing current and ongoing risk to public protection could be low, medium or high.*
>
> *169 Where the starting point for assessing risk is low, evidence of relevant context known about the doctor and/or their working environment and evidence of insight and remediation that decrease risk, will usually have more impact. This*

is because the risk to public protection, including the impact on public confidence, arising from clinical concerns falling at the lower end or mid-range of the spectrum of seriousness are generally easier to address.

170 *However, where the starting point for assessing risk is high, evidence of relevant context known about the doctor and/or their working environment and evidence of insight and remediation that decrease risk may have less impact because allegations falling at the higher end of the spectrum of seriousness can be more difficult to remediate. The MPT's decision on risk should reflect this and a conclusion the doctor poses a current and ongoing risk to public protection may be needed. If so, this will result in them finding that the doctor's fitness to practise is impaired.'*

What is the impact of any relevant context known about Dr Kidd and/or their working environment?

60. Paragraph 45 of the MPTS Guidance (*MPT Hearings > Part B: Stage two – Impairment)* states that there are three types of relevant context: working environment, role and experience, and personal context.

61. The Tribunal next considered whether there was any relevant context, which may have directly affected Dr Kidd's conduct at the material time. If so, whether it was appropriate to take that context into account. If so to confirm what impact it has on the assessment of whether Dr Kidd poses a current and ongoing risk to one or more parts of public protection and the level of such risk. Impact could be to decrease the level of risk, have no impact on the level of risk or it could increase the level of risk.

62. The Tribunal had regard to the evidence before it about Dr Kidd's working environment at the material time. In relation to his clinical experience, the Tribunal took into account that Dr Kidd was an experienced and specialist clinician who was called upon to assist with complex conditions.

63. The Tribunal took into account the evidence of Dr V who stated that:

'Patients were often referred for a second opinion to Dr Kidd, as their presentation was complicated and their diagnosis and management not straightforward. The majority of these patients had already seen another neurologist before being assessed by Dr Kidd, further highlighting that the diagnosis and management in none of these cases was straightforward.'

64. The Tribunal also had regard to the additional evidence submitted by Dr Q at this stage of proceedings, who stated that in terms of the workload and culture around the time Dr Kidd left the Trust, the neurology department was a relatively small department with close working relationships between neurologists. The workload was within expected range for a neurosciences centre and particularly high for super-specialised clinics of the type that Dr Kidd was running.

65. In relation to the working environment and arrangements made for Dr Kidd's patients following his departure from the Trust, the Tribunal noted that Dr Kidd left the Trust on 31 August 2022 and that from the evidence before it, there were gaps in all patients being reallocated to another clinician.

66. The Tribunal also noted the contents of the letter sent to the GMC by Dr Kidd's legal representatives, dated 25 April 2025, which provides:

> *'Dr Kidd had begun to prepare his patients for his inevitable retirement and would have sought to reassure patients, and their representative charity, that they he was involved in efforts to ensure that a suitable service was maintained following his retirement.*
>
> *…*
>
> *No one with his sub-specialist expertise had been appointed to replace him. In our submission, there can be no question but that for patients of that service Dr Kidd's departure meant the end of the neurosarcoidosis clinic as they knew it. Whilst the Royal Free might well make arrangements for patients to be seen by other neurologists at the Trust, that would be materially different from 'the clinic' which Dr Kidd, and the patients, would have in mind when discussing 'the clinic'.*
>
> *…*
>
> *It is clear that the Trust failed entirely to make any proper arrangements for the care of Dr Kidd's patients before Dr Kidd's departure and that they still had not done so by early November 2022. Given the nature of the patients' conditions and their reliance over years on Dr Kidd's clinic it should come as no surprise that patients were unsettled and concerned and that some of them contacted Dr Kidd.'*

67. The Tribunal had regard to the witness statement of Dr N who stated:

'… a locum had been organised to cover Dr Kidd's practice and to make sure that any patients needing an urgent review received it…'

68. The Tribunal also noted the evidence of Dr Q who stated that he was not aware of anyone with the specific clinical responsibility for Dr Kidd's patients immediately after Dr Kidd's departure from the Trust although Dr O, the Clinical Director for Neurology was overseeing any clinical issues. He could not say the number of patients whose care he took over. He said there was a database of former Dr Kidd patients whose care was assessed and were then either referred back to local neurologists if no specialist input was required, referred back to other specialties locally if that was more appropriate, or kept under review at the Hospital. He said he does not know the final number and the current manager has been unable to answer this question.

69. In light of this, the Tribunal accepted that the uncertainty about future care at the Trust may have caused some concern for patients, and that they had reached out to Dr Kidd for reassurance. The Tribunal concluded that Dr Kidd's actions may have been borne out of a desire to help, albeit wrongly.

70. The Tribunal next considered whether Dr Kidd's role and experience was material to its assessment of risk. It noted that, at the relevant time he was an experienced doctor, having worked as a consultant at the Hospital for a significant period of time. The Tribunal reminded itself of the guidance Paragraph 65 of the MPTS Guidance under the heading '*Assessing the impact of role and experience*' that a doctor in a senior or leading role is more likely to be capable of influencing others and having an impact on workplace culture and that where they behave inappropriately, their departure from the professional standards expected of them has an additional impact. The Tribunal concluded that Dr Kidd's role and experience had no impact on its assessment of the level of current and ongoing risk to the three parts of public protection. In light of this, the Tribunal's assessment of the level of risk remains high.

71. Furthermore, the Tribunal considered that any doctor, regardless of their role or experience, should be expected to know that acting dishonestly is wrong.

72. The Tribunal considered that Dr Kidd has not advanced any personal context to the Tribunal which might have an impact on its assessment.

73. Overall, the Tribunal did not consider that in this case, there was any relevant contextual feature which would impact its assessment of the level of risk posed by Dr Kidd to public protection.

How has Dr Kidd responded to the allegation(s)?

74. The Tribunal next considered Dr Kidd's response to the allegation. It had regard to all the evidence and considered

- whether Dr Kidd has shown insight into his own behaviour, and whether that insight is genuine;
- whether he had taken steps to remediate, assess if the allegation is remediable, has been remedied and if it was likely to be repeated;
- kept his knowledge and skills up to date; and
- confirmed what impact these factors have on the level of risk (do they decrease or increase the level of current and ongoing risk to public protection or do they have no impact).

75. The Tribunal reminded itself that it was required to answer these questions by reference to the facts found proved at the first stage of the hearing and further relevant evidence considered at the impairment stage.

Insight

76. The Tribunal assessed the extent of Dr Kidd's insight into his misconduct. It had regard to paragraph 81 of the MPTS Guidance under Step 2(d) which states:

> *'81 To demonstrate insight, and insight which is genuine, the doctor will need to show they understand what happened and accept how they could have acted differently. This involves showing, where relevant, that they have:*
>
> - *considered the allegation, understanding what went wrong and accept they should have acted differently*
> - *fully understood the impact or potential impact of their behaviour, performance, or health condition*
> - *empathy for any individual affected, for example by apologising*
> - *taken, or are taking, steps to remediate and to identify how they will act differently in the future to avoid similar issues arising*
> - *…'*

77. The Tribunal took into consideration that there was very little evidence before it to demonstrate insight. The Tribunal acknowledged that, during the complaint's investigation at

the Trust regarding his care of Patient B, Dr Kidd had acknowledged that he had made mistakes, particularly in relation to failing to seek approval for treatments. However, the Tribunal noted that Dr Kidd had not acknowledged that he acted dishonestly.

78. The Tribunal noted that in these proceedings, Dr Kidd has not accepted responsibility for his own actions.

79. The Tribunal also noted that in his letter to the GMC in advance of these proceedings, Dr Kidd stated:

> *'The allegations in this case are essentially a manifestation of management irritation and misrepresentation. I see these proceedings and the complaints against me as an egregious and authoritarian act of subdual in order to prevent my moving the unit to a safer, more productive and supported environment in another hospital prior to retirement, and in doing so to protect the existing and future patients with this uncommon condition.'*

80. The Tribunal has seen no evidence of genuine remorse or insight. In the absence of that evidence, the Tribunal concluded that there had been no reduction in the level of current and ongoing risk to public protection.

Remediation

81. The Tribunal had regard to the MPTS Guidance (*Guidance introduction > Protecting the public in specific case types > Case type 2: dishonesty)* at paragraphs 90 and 91 and (*Guidance introduction > Protecting the public in specific case types > Case type 5: clinical concerns)* at paragraphs 168 to 170 as set out above.

82. The Tribunal carefully considered whether Dr Kidd has provided any evidence that he has remediated his misconduct in relation to the clinical concerns. The Tribunal concluded, whilst the clinical concerns raised were remediable, there was no evidence on any remediation by Dr Kidd.

83. The Tribunal also considered whether Dr Kidd has provided any evidence that he has remediated his misconduct in relation to his dishonesty. The Tribunal concluded that there was no evidence of remediation.

84. The Tribunal acknowledged that, whilst dishonesty is difficult to remediate, there are steps that a practitioner can take and strategies that they can develop to demonstrate a

reduction in the risk that they will behave in a similar way in future. However, in this case there has been no evidence provided by Dr Kidd to demonstrate this.

85. The Tribunal determined that in this case there was no evidence of insight or remediation. Consequently, the Tribunal decided that it could not be reassured that Dr Kidd would be highly unlikely to act in a similar way in future.

Keeping knowledge and skills up to date

86. The Tribunal noted that there were no specific complaints made by the GMC about Dr Kidd's knowledge and skills, but it noted no evidence before it to show that Dr Kidd has kept up to date with training and new guidelines or developments since he left the Trust. The Tribunal had regard to paragraphs 124 and 125 of the MPTS Guidance under Step 2(d) which state,

> *'124 Where a doctor has not been working for a period since the circumstances giving rise to the allegation arose, either at all or in a specific speciality, the MPT may consider that this creates a risk that the doctor's knowledge and skills have deteriorated. It's therefore important that the doctor can evidence they have taken steps to mitigate this risk.*
>
> *125 Where the doctor can show that their knowledge and skills are up to date despite any break from practice, this will not usually directly impact on the assessment of current and ongoing risk to public protection because being competent in all aspects of their work and able to provide a good standard of practice and care is a key requirement of the professional standards.'*

87. The Tribunal has limited information as to what Dr Kidd has been doing professionally since he ceased working at the Trust in August 2022, other than Dr Kidd stating he has left the country and is not practising. The Tribunal took into account that Dr Kidd was a doctor with significant experience at the time of the incidents giving rise to the allegations. There was nothing before the Tribunal that would indicate that he has kept his knowledge and skills up to date since his departure from the Trust. In the absence of this evidence, the Tribunal considered that this had no impact on its assessment of risk.

88. Overall, the Tribunal concluded that Dr Kidd's response to the allegation did not reduce the level of risk he poses to public protection.

Tribunal's decision as to whether Dr Kidd poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment

89. The Tribunal next had to consider, overall, whether Dr Kidd poses any current and ongoing risk to public protection which may require restrictive action on his registration, and its decision on impairment.

90. The Tribunal reviewed its conclusions at Steps 2(a) to (d) above. It has found that Dr Kidd's misconduct lies at the high end of the spectrum of seriousness. The Tribunal has considered the known contextual factors relating to Dr Kidd and has taken into account his response to the allegation. However, the Tribunal has concluded that neither the contextual factors it has identified, nor Kidd's response to the allegation, has decreased the current and ongoing risk which he presents to public protection.

91. The Tribunal had regard to the General Introduction section of the MPTS Guidance, and specifically the sections headed '*Case type 2: dishonesty'* and *'Case type 5: clinical concerns'.* Paragraph 87 of the General Introduction sets out how the three parts of public protection might be engaged in a dishonesty case. Paragraph 165 likewise sets out how the three parts of public protection might be engaged in a case involving clinical concerns, in similar terms.

92. The Tribunal considered that all three parts of public protection are engaged in the current case:

Protecting, promoting and maintaining the health, safety and wellbeing of the public

93. The Tribunal considered that there was no evidence before it that any patients had been harmed by Dr Kidd's actions. However, the Tribunal noted that there was a potential for harm from his conduct, particularly in relation to his actions towards Patient B, and his post-departure conduct. The Tribunal was of the view that providing a patient with a diagnosis they did not have could have caused significant distress to that patient. Further, it could have led to the patient being sent down a route of treatment that was not clinically necessary or appropriate.

94. The Tribunal also acknowledged that there were inherent risks to patients in failing to follow clinical governance structures, such as getting approval for a course of treatment when required. An example of this is the case of Patient B, who received IVIG treatment when it was not indicated, which meant that Dr Kidd put Patient B at risk of infection, allergic reaction and blood clots.

95. Further, the Tribunal considered that there could be a real risk to patients if Dr Kidd was continuing to contact them without the knowledge of clinicians who have taken over their care.

96. In the absence of any insight by Dr Kidd into his misconduct or steps taken to remedy it, the Tribunal was not reassured that he would be highly unlikely to act in a similar way in future. Accordingly, the Tribunal considers that Dr Kidd poses a current and ongoing risk to the health, safety and wellbeing of the public and that a finding of impairment is required on public safety grounds.

Promoting and maintaining public confidence in the profession

97. As to the second part of public protection, confidence in the profession, the Tribunal was in no doubt that Dr Kidd's misconduct brings the medical profession into disrepute and that he has breached a fundamental tenet of the medical profession, including to be honest. The public must have confidence that doctors will behave with honesty and integrity, and dishonesty undermines public trust. The Tribunal considered that the public would be rightly appalled by a doctor dishonestly claiming affiliations to institutions that he did not have in published articles or knowingly providing an inaccurate diagnosis to a patient. The Tribunal concluded the misconduct was of such a serious nature that a finding of impairment is necessary to maintain public confidence in the profession.

Promoting and maintaining professional standards and conduct (upholding professional standards)

98. As to the third part of public protection, upholding professional standards, the Tribunal reminded itself of its earlier conclusion that Dr Kidd's conduct represented a serious departure from the standards of conduct expected of medical practitioners. The Tribunal considered that a finding of impairment is required to send a clear signal to Dr Kidd, the profession, and the public of the unacceptability of his conduct.

99. In all the circumstances, the Tribunal concluded that the current and ongoing risk posed by Dr Kidd to public protection is high, and that a finding of impairment is necessary, by reference to all three parts of public protection.

100. The Tribunal has therefore determined that Dr Kidd's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 13/03/2026

1. This determination was handed down in public. However, the Tribunal exercised its powers under Rule 41 of the Rules, to sit in private when the matters under consideration were confidential.

2. Having determined that Dr Kidd'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.

Submissions

3. On behalf of the GMC, Mr Rigby submitted that the Tribunal's findings severe as they are, together with the MPTS Guidance, does direct the Tribunal to two conclusions: suspension or erasure. He submitted, in reality, the Tribunal, if following the MPTS Guidance to the letter may conclude that erasure is the only outcome.

4. Mr Rigby submitted that the decision as to the appropriate sanction, if any, is a matter for the Tribunal exercising its own independent legal judgment. He directed the Tribunal to the MPTS Guidance (*MPT Hearings > Part C: stage three – sanction > Step 3: decide on sanction*). At stage three of an MPT hearing the Tribunal will consider what regulatory action, if any is needed to protect the public. He submitted that the Tribunal has to consider what sanction is a proportionate regulatory response to protect the public. He said that, under the most recent MPTS Guidance, there is even greater emphasis on public protection, or what used to be more commonly referred to as the overarching objective.

5. Mr Rigby stated that the Tribunal had decided in this case that all three parts of public protection are engaged. The outcomes that are available to the Tribunal are to:

- take no action;
- impose conditions on Dr Kidd's registration for up to three years;
- suspend Dr Kidd's registration for up to 12 months, or
- erase Dr Kidd's name from the medical register

6. Mr Rigby submitted that any sanction imposed must be proportionate and fair. Taking no action was not a proportionate response in this case given the Tribunal's findings at the Impairment stage. He said Dr Kidd is not practising and is now out of the country, but, as the Tribunal noted at the impairment stage, there was nothing to stop him from returning to practise if no restrictive action is taken.

7. Mr Rigby stated that the Tribunal had determined that there was a significant risk to all parts of public protection. The Tribunal should decide on the sanction and ensure it is

proportionate. He referred to the Sanction Bandings for Case type 2: dishonesty and Case type 5: clinical concerns and stated that the Tribunal should act in line with those guidelines. He submitted that suspension is for those cases were the current and ongoing risk needs to be managed for a period. He submitted that in this case erasure was the only proportionate response, referring the Tribunal to paragraph 57 of the MPTS Guidance (*MPT Hearings > Part C: stage three – sanction > Step 3: decide on sanction*).

The Tribunal's Determination on Sanction

8. At this stage, as the Tribunal has decided that Dr Kidd's fitness to practise is impaired it will now consider what is a proportionate regulatory response, if any which is needed to protect the public. At the impairment stage, the Tribunal determined that all three aspects of public protection were engaged. It is for the Tribunal now to consider what regulatory action, if any is needed to protect the public. When deciding whether to impose a sanction, Tribunal must consider the legal duty under the Medical Act to protect the public.

9. The Tribunal accepted legal advice and the procedure to be adopted under the MPTS Guidance (*MPT Hearings > Part C: stage three – sanction > Step 3: decide on sanction*). It has borne in mind that the purpose of a sanction is not to be punitive, but to protect patients and the wider public interest, although it may have a punitive effect.

10. In making its decision on sanction, the Tribunal has reviewed its decisions on the facts and impairment and has considered the level of current and ongoing risk that Dr Kidd poses to public protection. It has also considered the sanctions banding for cases involving dishonesty and clinical concerns as set out in the MPTS Guidance.

11. The Tribunal is directed to consider those bandings when reaching its decision as to the appropriate sanction. The bandings are a guide. The decision on the appropriate sanction if any, is a matter for the Tribunal exercising its own independent legal judgment.

12. In reaching its decision, the Tribunal has to take account of the parties' submissions, the MPTS Guidance and the public protection. The Tribunal will consider whether there is relevant evidence relating to the impact a certain type of sanction will have and/or relevant references and testimonials where available and what impact, if any, they have. No testimonials or references have been received from Dr Kidd in this case. No adverse inference has been drawn from this fact.

13. The Tribunal will decide on the type and length of sanction. It has to stand back and check if it is proportionate to meet the level of current and ongoing risk posed to public protection.

14. The Tribunal had regard to the submissions made by Mr Rigby on behalf of the GMC and the MPTS Guidance *(Guidance introduction > Protecting the public in specific case types > Case type 2: dishonesty)* at paragraphs 96 to 97:

> *'96 The proportionate sanction in response to an allegation of dishonesty will depend on the extent of the doctor's behaviour and the impact it's assessed to have on each of the three parts of public protection.*
>
> *97 Where the level of current and ongoing risk to public protection is medium or high, this will require consideration of suspension or erasure.'*

15. In this case the Tribunal determined at the impairment stage that Dr Kidd's misconduct relating to the dishonesty concerns falls at the higher end of the spectrum of seriousness and that the current and ongoing risk to public protection was high. The sanctions banding in this case gives a starting point of nine months suspension to erasure.

16. The Tribunal also had regard to the MPTS Guidance *(Guidance introduction > Protecting the public in specific case types > Case type 5: clinical concerns)* at paragraph 174 to 176:

> *'174 The proportionate sanction in response to an allegation relating to a clinical concern will depend on the extent of the doctor's behaviour and/or poor performance and the impact it's assessed to have on each of the three parts of public protection.*
>
> *175 Where the level of current and ongoing risk to public protection is low or medium, conditions will often be the proportionate response.*
>
> *176 Suspension or removal are only likely to be needed where the assessment of risk is high based on the case falling at the higher end of the spectrum of seriousness, there being relevant context known about the doctor and/or their working environment that increases risk and/or because the doctor has shown a lack of insight and/or is not willing or able to remediate.'*

17. In this case, the Tribunal determined that Dr Kidd's misconduct relating to clinical concerns fell at the higher end of the spectrum of seriousness and that the current and ongoing risk to public protection was high, so it falls within the sanctions banding of suspension of six months to erasure.

18. Where there is more than one type of proven allegation, the MPT should impose the sanction that addresses the risk posed by the most serious findings. The most serious findings in this case are the findings relating to the dishonesty concerns.

19. The MPTS Guidance makes clear that the parties should be made aware from the outset the approach that the Tribunal will take to imposing sanctions. The Tribunal should use its own judgment to make decisions but must base its decisions on the standards of good practice established in GMP and on the advice given in the MPTS Guidance.

20. The Tribunal reminded itself that the sanctions bandings are intended to provide a guide, and that there may be evidence relevant to the individual circumstances of the case that indicates a sanction which is more or less restrictive than that suggested in the bandings.

21. The Tribunal considered each of the available sanctions in turn, starting with the least restrictive.

No action

22. The Tribunal considered that there are no exceptional circumstances in this case which would warrant the taking of no action in the context of the facts found proved and the Tribunal's determination on impairment. It considered that taking no action would not be sufficient, proportionate, or in the public interest.

Conditions

23. The Tribunal next considered whether to impose conditions on Dr Kidd's registration. It noted paragraphs 19 and 20 of the relevant section of the MPTS Guidance and bore in mind that any conditions imposed would need to be appropriate, proportionate, workable and measurable.

24. As a starting point, the Tribunal considered that the sanctions banding for this case type does not indicate that conditions would be sufficient to meet the level of risk to public protection. Moreover, given the seriousness of Dr Kidd's conduct, the Tribunal did not consider that the imposition of conditions would be a proportionate or appropriate response sufficient to satisfy its determined level of the current and ongoing risk to public protection.

The Tribunal further considered that it would not be possible to formulate conditions to address Dr Kidd's conduct and, as such, conditions would be unworkable in this case. In all the circumstances, the Tribunal concluded that a period of conditional registration would not be an appropriate or proportionate sanction and would not satisfy the public interest.

Suspension

25. The Tribunal then went on to consider whether imposing a period of suspension on Dr Kidd's registration would be appropriate and proportionate. The Tribunal acknowledged that suspension has a deterrent effect and bore in mind the sanctions banding tables, referred to above.

26. The Tribunal noted paragraphs 44 and 45 of the relevant section of the MPTS Guidance, which provide:

> *'44 Restrictive action of suspension is intended to address the level of current and ongoing risk to public protection and is not intended to be punitive. However, as it prevents a doctor from working and earning a living within that profession, it can have this effect. Suspension can also have a deterrent effect and be used to send a signal to the individual doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor.*
>
> *45 Suspension may be proportionate in cases where some, or all, of the following factors are present:*
>
> *a conditions are not appropriate, measurable and/or workable*
>
> *b the level of current and ongoing risk to public protection is such that it cannot be safely managed with conditions and suspension is necessary to stop the doctor from working and putting patients at risk while they gain insight into any deficiencies and remediate, or undergo medical treatment, and/or*
>
> *c the level of current and ongoing risk to public protection is such that, although patient safety is not an issue, suspension is needed to maintain public confidence in the profession and/or maintain professional standards.'*

27. The Tribunal acknowledged that dishonesty in any form is serious, although there are different degrees of dishonesty. It noted that there was no evidence that Dr Kidd had gained anything from his dishonesty. Further, there was no evidence of actual harm to patients,

although the Tribunal acknowledged that there was a risk of harm arising from Dr Kidd's actions.

28. The Tribunal took into account its assessment on insight and remediation, at the impairment stage and noted the absence of any evidence which demonstrated that Dr Kidd had an understanding of his wrongdoing, and how he could prevent future repetition. It was satisfied that Dr Kidd's conduct could be remedied, but that he has not yet taken those steps.

29. The Tribunal accepted that Dr Kidd has had a long career with no previous adverse history with his regulator and was therefore of previous good character. No testimonials or references were provided for Dr Kidd. The Tribunal did not draw any adverse inference from this. The Tribunal noted that, whilst no testimonials had been provided, the Tribunal had before it other evidence contained within the bundle, including correspondence from patients to the Trust. This information suggested that that Dr Kidd is a good doctor, who was well regarded by his patients. The Tribunal took this into account and accepted that Dr Kidd had been trying to do his best for his former patients, albeit he went about it the wrong way.

30. The Tribunal then went onto consider whether erasure was the most appropriate and proportionate sanction, as required by the MPTS Guidance. It had regard to paragraphs 55 and 57 of the relevant section of the MPTS Guidance, which provides:

> *'55 Erasure is action available for those cases where a doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is incompatible with continued registration at this point in time. It means the level of current and ongoing risk the doctor poses to public protection is so significant that they should not be allowed to practise.*
>
> ...
>
> *57 Erasure may be the proportionate response where:*
>
> ***a** conditions are not appropriate, measurable and/or workable and suspension is not sufficient to protect the public*

b the doctor's behaviour or performance is such that it caused serious harm, and the risk of harm recurring cannot be mitigated sufficiently through putting conditions or suspension in place

c the doctor has shown a persistent lack of insight into the seriousness of the allegation about their behaviour or performance and the potential or actual consequences, and/or

d the seriousness of the facts found proven and/or impact of any relevant context that increased the current and ongoing risk to public protection mean the effect of the doctor continuing to hold registration is such that it will undermine public confidence in the profession.'

31. Although the misconduct found proved was serious, the Tribunal was not satisfied that it was so serious that it warranted complete removal from the register. It determined that erasure would be disproportionate, having regard to Dr Kidd's long, and otherwise unblemished, career, that Dr Kidd had little to gain from this misconduct and that, although misguided, he was trying to act in the best interests of his patients. Further, it was satisfied that it was possible for Dr Kidd to remediate his conduct and to develop his insight. Consequently, the Tribunal did not find that Dr Kidd's misconduct was incompatible with continued registration at this point in time. The Tribunal was satisfied that the public can be protected and professional standards upheld through a period of suspension. The Tribunal was also satisfied that, in the circumstances as outlined above, public confidence would not be undermined by allowing Dr Kidd to continue to hold his registration despite the seriousness of the facts found proven and the current and ongoing risk to public protection.

32. Having regard to its findings as set out above, and given the circumstances of this case, the Tribunal determined that suspension is the most appropriate sanction. The Tribunal then went on to consider the length of suspension and whether to direct a review prior to the end of the period of suspension.

Length of suspension

33. In determining the length of suspension, the Tribunal had regard to paragraph 46 of the relevant section of the MPTS Guidance which states:

'46 The MPT will need to decide the appropriate length of time that suspension should be put in place for, up to the maximum of 12 months. The following factors will be relevant:

a the assessment of the level of current and ongoing risk to public protection posed by the doctor

b the reasons for assessing suspension as being the proportionate response

c the amount of time the doctor is likely to need to remediate, complete treatment for and/or recover from a health condition that is having, or is likely to have, an impact on their ability to practise safely and effectively, and/or

d the amount of time the parties will reasonably need to prepare for any review of whether the doctor continues to pose a current and ongoing risk to public protection requiring restrictive action in response or is safe to return to unrestricted practice.'

34. The Tribunal considered that a short period of suspension would not adequately mark the gravity of the misconduct nor send a message that such serious misconduct was unacceptable. The Tribunal was of the view that Dr Kidd needed sufficient time to develop insight and remediate his conduct. The Tribunal considered that a lengthier period of suspension would be the most appropriate for these reasons.

35. The Tribunal acknowledged that a period of suspension would undoubtedly have an impact on Dr Kidd, but was of the view that this is outweighed by the need to uphold professional standards and maintain public confidence in the profession.

36. The Tribunal concluded that a period of suspension for 12 months was the appropriate and proportionate response. This period reflects the seriousness of Dr Kidd's misconduct.

Review

37. The Tribunal determined to direct a review of Dr Kidd's case. A review hearing will convene shortly before the end of the period of suspension. The Tribunal wishes to clarify that, at the review hearing, the onus will be on Dr Kidd to demonstrate how he has developed insight and remediated his misconduct. It therefore may assist the reviewing Tribunal if Dr Kidd provides:

- Evidence that his knowledge and skills are up-to-date;
- Evidence of his remediation;

- Evidence of his development of insight; and
- any other information that he considers will assist.

Determination on Immediate Order - 13/03/2026

1. This determination was handed down in public. However, the Tribunal exercised its powers under Rule 41 of the Rules, to sit in private when the matters under consideration were confidential.

2. Having determined that Dr Kidd's registration should be suspended for a period of 12 months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

3. On behalf of the GMC, Mr Rigby submitted that an immediate order should be imposed in this case. He referred the Tribunal to the MPTS Guidance (*MPT Hearings > Part C: stage three – sanction > Step 3: decide on sanction > Immediate and interim orders following sanction).* He reminded the Tribunal that there has been no cooperation from Dr Kidd, and his current circumstances are unknown, beyond being aware that he is not presently practising in the UK. He submitted that there should be an immediate order for the benefit of the public, bearing in mind the Tribunals findings.

The Tribunal's Determination

4. The Tribunal considered that it may impose an immediate order if it considers it necessary for the protection of members of the public or is otherwise in the public interest. The decision whether to impose an immediate order is at the discretion of the Tribunal, based on the facts of the case.

5. The Tribunal had regard to paragraphs 83 and 84 of the MPTS Guidance (*MPT Hearings > Part C: stage three – sanction > Step 3: decide on sanction > Immediate and interim orders following sanction)*, which provide:

> *'83 The decision whether to impose an immediate order is at the discretion of the MPT based on the facts of the case. When deciding if an immediate order is needed the MPT should consider the seriousness of the proved allegation and the level of current and ongoing risk to public protection posed by the doctor.*

84 *It will not usually be appropriate for a doctor to hold unrestricted registration until a sanction takes effect in cases where:*

a the doctor poses a risk to patient safety

b the risk to one or more parts of public protection is high, and/or

c immediate action is needed to maintain public confidence in the medical profession.'

6. The Tribunal considered that, in light of its previous determinations regarding the seriousness of Dr Kidd's conduct and its assessment of the level of Dr Kidd's current and ongoing risk to public protection, an immediate order was necessary in this case. It considered that all three parts of public protection were engaged and that, the factors set out in paragraph 84 were present and indicated that an immediate order was necessary.

7. This means that Dr Kidd's registration will be suspended from the date on which notification of this decision is deemed to have been served upon him. The substantive direction, as already announced, will take effect 28 days from that date, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

8. That concludes this case.

ANNEX A – 23/02/2026

Service and proceeding in absence

Service

1. Dr Kidd was not present or represented at this Medical Practitioners Tribunal ('MPT') hearing. The Tribunal therefore considered whether the relevant documents had been served in accordance with Rule 40 of the General Medical Council ('GMC') Fitness to Practise Rules 2004 ('the Rules') and paragraph 8 of Schedule 4 of the Medical Act 1983.

2. Mr Rigby, Counsel, on behalf of the GMC, drew the Tribunal's attention to various documents regarding service of the notice of hearing. These included:

- Screenshots of Dr Kidd's registered address and email address;
- Email from Dr Kidd to GMC enclosing letter regarding attendance at MPT hearing, dated 6 January 2026;
- Email from GMC to Dr Kidd enclosing Notice of Allegation and final Rule 15 allegations, dated 20 January 2026;
- Email from MPTS to Dr Kidd enclosing Notice of Hearing, dated 20 January 2026.

3. Mr Rigby submitted that service had been effected in accordance with Rule 40 of the Rules by reason of the documents set out within the service bundle. He submitted that it was the duty of the registrant to notify the regulator of their address. In addition to serving notice on Dr Kidd to his registered address, the GMC had also given notice of these proceedings to Dr Kidd via an email address that Dr Kidd has used in recent correspondence.

4. The Tribunal had regard to the documents before it and the submissions made by Mr Rigby. It was satisfied that notice of this hearing has been served in accordance with Rule 40 of the Rules and paragraph 8 of Schedule 4 of the Medical Act 1983.

5. It noted that whilst Dr Kidd had indicated that he was no longer at his registered postal address, which he had not updated, notice had also been served on him at an email address from which he had responded, and where he explicitly stated that he was aware of the proceedings and had provided some representations.

Proceeding in Absence

6. Having been satisfied that notice was properly served upon Dr Kidd, the Tribunal then considered whether to proceed with this hearing in his absence, in accordance with Rule 31 of the Rules. The Tribunal was conscious that the discretion to proceed in the absence of a

doctor should be exercised with the utmost care and caution, balancing the interests of the doctor with the wider public interest.

Submissions

7. Mr Rigby invited the Tribunal to proceed in the absence of Dr Kidd, pursuant to Rule 31 of the Rules. He referred the Tribunal to the cases of *R v Jones [2003] 1 AC 1* and the *General Medical Council v Adeogba [2016] EWCA Civ 162*.

8. Mr Rigby submitted that Dr Kidd had deliberately waived any right that he may have to attend and had set out in correspondence to the GMC that he did not wish to attend and would not be doing so. In addition, Dr Kidd and solicitors acting for him had made representations in correspondence which appeared in the hearing bundle. Mr Rigby submitted that Dr Kidd is aware that the hearing would proceed in his absence and that in all the circumstances, the Tribunal should exercise its discretion and continue with the hearing.

The Tribunal's Determination

9. In reaching its decision, the Tribunal considered the submissions made on behalf of the GMC and the evidence before it, as set out above. It took into account the need to approach its decision with the utmost care and caution.

10. The Tribunal considered that Dr Kidd's correspondence stated that he was aware of the hearing and would not be attending.

11. The Tribunal was satisfied that Dr Kidd had made it clear in his correspondence to the GMC that he did not wish to attend the proceedings and had voluntarily absented himself.

12. The Tribunal was not provided any evidence that Dr Kidd had sought an adjournment or that an adjournment would secure his attendance at any future date.

13. The Tribunal has balanced Dr Kidd's interests with the public interest in deciding whether to proceed in his absence. The Tribunal was satisfied that Dr Kidd had voluntarily absented himself from these proceedings and that it was in the public interest that the hearing proceeded in a timely manner.

14. Having considered all the circumstances, the Tribunal determined that it was fair and reasonable to proceed in Dr Kidd's absence in accordance with Rule 31 of the Rules. The Tribunal was satisfied that it was in the interests of justice to do so.

SCHEDULE 1

Neurosarcoidosis: clinical manifestations, investigation and treatment. Practical Neurology 2020;20:199-212. Accepted 5 January 2020

Relapse of severe neurosarcoidosis with switch from originator infliximab to biosimilar. Neurology Journals 2020 Jun 2;94(22):991-993

Sarcoidosis of the central nervous system: Safety and efficacy of treatment, and experience of biological therapies. Clinical Neurology and Neurosurgery 2020 Jul;194:105811

Granulomatous CNS inflammation associated with seminoma. Journal of Neurology 2019 Jun;266(6):1389-1393

SCHEDULE 2

13 September 2022

20 September 2022

27 October 2022

30 October 2022

On or around 13 September 2022 and 30 October 2022