Neutral Citation Number: [2026] EWHC 1138 (Admin)

Case No: AC-2025-LON-002891

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 19 May 2026

Before :

THE HONOURABLE MR JUSTICE MURRAY

- -

Between :

PROFESSIONAL STANDARDS AUTHORITY FOR HEALTH AND SOCIAL CARE

Appellant

- and -

(1) GENERAL MEDICAL COUNCIL
(2) CÍAN HUGHES

Respondents

- -
- -

Mr David Hopkins (instructed by **Browne Jacobson LLP**) for the **Appellant**
Ms Rebecca Harris KC (instructed by **Weightmans**) for the **Second Respondent**
The **First Respondent** was represented by **GMC Legal** on a noting brief only.

Hearing date: 10 March 2026

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Approved Judgment

This judgment was handed down remotely at 10.30am on 19 May 2026 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Mr Justice Murray:

1. This is an appeal under section 29 of the National Health Service Reform and Health Care Professions Act 2002 ("the 2002 Act") by the appellant, the Professional Standards Authority for Health and Social Care ("the Authority"), against a decision dated 4 June 2025 ("the Decision") of a Medical Practitioners Tribunal ("the Tribunal") of the first respondent, the General Medical Council ("the GMC"), to impose a sanction of suspension for 12 months rather than a sanction of erasure from the register on the second respondent, Cían Hughes, a doctor registered with the GMC, following the Tribunal's finding that Dr Hughes's fitness to practice was impaired by various instances of misconduct in relation to a patient ("Patient A").

2. The Authority appeals on the following grounds:

   i) Ground One: The Tribunal erred by finding that a suspension order was a sufficiently serious sanction having regard to the Tribunal's factual findings and the nature of Dr Hughes's misconduct.

   ii) Ground Two: Alternatively, the Tribunal erred by finding that Dr Hughes had not exploited Patient A's vulnerability and had it not made such an error, the Tribunal would have been obliged to impose an erasure order on Dr Hughes as the only sanction reasonably open to it.

3. The Authority asks the Court to quash the Decision and substitute for the Tribunal's order suspending Dr Hughes from practising for a period of 12 months an order erasing his name from the register. It also seeks an order that its costs of this appeal be paid by the first and/or the second respondent.

4. At the beginning of the hearing, I imposed a reporting restriction under CPR r 39.2(4) to protect the identity of Patient A, as I considered that it was necessary to do so having regard to her rights under Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), which, in the circumstances of this case, outweigh the right to freedom of expression under Article 10 of the ECHR of anyone who might wish to report on the case. This limited derogation from the principle of open justice does not prevent the case being reported on but simply prevents the reporting of any factual matter concerning Patient A that, if included in any publication, might lead a member of the public to identify her as the person referred to as "Patient A" in these proceedings, such as her name, address, image, or other information tending to identify her.

5. At this appeal, the Authority is represented by Mr David Hopkins, and Dr Hughes is represented by Ms Rebecca Harris KC, who represented him at the hearing before the Tribunal.

Factual background

6. The factual background and initial allegations against Dr Hughes are set out succinctly in the Tribunal's Record of Determinations, as follows:

> "2. Dr Hughes qualified in 2012 at the University of Bristol. At the time that Dr Hughes met Patient A in 2011, Dr

> Hughes was a fourth-year student at the University of Bristol. Following qualification, Dr Hughes completed his Foundation Years training and worked in a number of hospitals in London as a middle grade doctor between 2015 and 2022. Dr Hughes also undertook work for Google DeepMind Health from 2015 and continues to work for Google in Ireland.

> 3. The allegation that has led to Dr Hughes' hearing is as follows. On or around 10 March 2011 Dr Hughes observed a procedure on Patient A (a minor) at Bristol Royal Hospital for Children. After Patient A's discharge in April 2011, Dr Hughes sent messages to Patient A between 2011 and November 2013 which were inappropriate in that: he used his professional position to pursue an improper emotional relationship with Patient A, the messages were not part of Patient A's medical care, he sent the messages directly to Patient A and no one else, and he was aware that Patient A had developed personal feelings for him from April 2013.
>
> 4. It is further alleged that from December 2013 Dr Hughes used his professional position to pursue an improper emotional relationship with Patient A in that he sent messages to her which were inappropriate in that: he was aware that Patient A had developed personal feelings for him from April 2013 or December 2013, the messages were not part of Patient A's medical care, he sent the messages directly to Patient A and no one else and the nature of the messages became personal and more frequent.
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> 5. It is alleged that the messages Dr Hughes sent to Patient A from 12 October 2014 were with the intention of pursuing a sexual relationship with Patient A and were sexually motivated. Further that Dr Hughes entered into a sexual relationship with Patient A in that, on one or more occasions from October 2014 he kissed Patient A, from February 2015 engaged in sexual activity with Patient A, and from 29 May 2015 he engaged in sexual intercourse with Patient A. It is finally alleged that Dr Hughes knew that Patient A was vulnerable at all material times by virtue of her age prior to turning 18, and her mental state, in that she was suffering from an eating disorder and more than one incident of self-harm."

7. When Dr Hughes met Patient A in March 2011, he was 23 years old, having been born on 27 January 1988. He was then a fourth-year medical student at Bristol University, from which he graduated in July 2012. He qualified as a doctor and gained provisional registration with the GMC on 23 July 2012, attaining full registration on 7 August 2013. He has since acquired a number of additional medical qualifications.

As noted in the Tribunal's summary of the background which I have quoted above, Dr Hughes joined Google in August 2015 as part of DeepMind Health, becoming part of Google Health in 2018. He moved back to Ireland in 2022 to continue his role with Google. He currently works in Dublin and has not undertaken any clinical practice in the UK since 17 December 2021. He is dual-registered with the GMC and the Irish Medical Council, which has been monitoring the proceedings before the Tribunal as well as this statutory appeal.

8. In March 2011, at the time of her first contact with Dr Hughes, Patient A was 13 years old, having been born in mid-1997. She suffers from cerebral palsy spastic diplegia, as a result of which she was then, and is now, a wheelchair user and cannot walk unaided.

9. In March 2011, Patient A was under the care of Mr Martin Gargan, a consultant surgeon at Bristol Royal Hospital for Children ("BRHC"). Dr Hughes, as part of his training, was undertaking an assessment in Paediatric Orthopaedics under the supervision of Mr Gargan.

10. On 10 March 2011, Patient A had a multi-level muscle lengthening operation at BRHC. Dr Hughes observed the surgery as part of his training. He was also collaborating with Mr Gargan on an article on cerebral palsy for the *Journal of Trauma & Orthopaedics*. He was told that Patient A's case would be a good case study for the article along with a couple of other cases.

11. On 15 March 2011, Dr Hughes attended at Patient A's bedside on the ward where she was staying for purposes of her recovery and rehabilitation. He introduced himself and explained to her that he was writing an article about cerebral palsy. He showed her some of her x-rays, and she asked whether she could have copies of them. As patients were permitted to take pictures of their x-rays, but she did not have a camera, Dr Hughes agreed to email them to her. He asked for her email, and that day he sent her the x-rays from his personal email address. In his evidence to the Tribunal, he said that he used his personal email address because he could not access his nhs.net email address on that day due to issues with his password.

12. At 19.03 on 15 March 2011, Dr Hughes sent Patient A an email with the x-rays attached but no accompanying message. Patient A responded at 20.43, "Thanks for the most interesting bio lesson of my life". The following day at 20.53, Dr Hughes sent a message reading:

> "No worries, let me know if you have any other questions. Hope you are still okay with us using your photo in our paper. Do you know if/when your mum might be in on Friday so that I can get you and her to sign a consent form? All the best, Cían Hughes".

13. Patient A responded a few minutes later asking which email address she should give her mother. Dr Hughes responded about 40 minutes after that saying that she should give her mother his nhs.net email address as he had now remembered his password.

14. The next exchange of messages was initiated on 21 March 2011 by Patient A with a query about whether he would review some science homework that she was doing.

There were further email exchanges on 28, 29 and 30 March, and 6 and 13 April 2011, prior to Patient A's discharge from hospital on 14 April 2011. These messages generally dealt with science questions that Patient A had and the progress of the article that Dr Hughes was writing, a draft of which he shared with her on 6 April 2011 via Dropbox from his nhs.net email address.

15. Patient A and Dr Hughes continued sporadically to exchange email messages during the following months, with Patient A generally initiating each exchange. Topics discussed included her schoolwork, the progress of her physiotherapy, and Dr Hughes's article. There were just under thirty email messages exchanged between 15 March 2011 and the end of that year.

16. The email exchanges continued into 2012, dealing with similar topics but also discussing her interest in riding.

17. On 26 May 2012, Patient A sent Dr Hughes some poetry that she had written. On 7 June 2012, Dr Hughes responded saying that he had taken some time to respond because she "deserved more than a one line". He noted that that some of the poetry raised the issues of suicide and self-harm, and he advised her that if she had such thoughts in relation to herself, it was important that she shared those feelings with the people around her. On 23 June 2012, Patient A responded, referring to bullying she had experienced at school due to being both clever and disabled and reassuring Dr Hughes that she did talk to people about how she felt, although it was generally easier to write about it "and the whole suicide/self harm thing isn't all about me".

18. The email exchanges continued during the remainder of 2012. It was the GMC's case during the proceedings before the Tribunal that during this time the email conversation was becoming increasingly more personal and conversational. For example, there was a reference in one of the messages to Dr Hughes's "green socks", which was an in-joke between them.

19. No messages were exchanged in January and February 2013, but on 7 March 2013 Patient A sent a message headed "Nearly 2 years on", referring to the date of her surgery on 10 March 2011. She asked how he was doing and how his surgical placement was going, and she apologised for not having been in touch for ages. She sent some more poetry that she had written, and she said that:

> "… These 2 years have been a bit of a roller coaster ride, but I don't think it would have [been] as easy without your support."

20. Dr Hughes responded that day to say that he was glad to have been of some support, asked whether more could have been done two years earlier to prepare her better for her surgery, and praising and encouraging her poetry.

21. There were further email exchanges during the remainder of 2013, during which they spoke about various matters including the progress of Dr Hughes's medical career and the progress of Patient A's schoolwork and her thoughts about universities.

22. On 28 October 2013, in response to a request via email from Patient A on 26 October 2013 for help in relation to a school project, Dr Hughes sent Patient A an iMessage containing links to three documents that she might find useful.

23. Four further emails were exchanged in December 2013, during which Patient A thanked Dr Hughes for the links, made reference to universities, and asked him to look at more of her poems. Dr Hughes offered to give her information regarding Irish universities.

24. For Christmas 2013, Patient A's parents gave her an iPod Touch, which facilitated communication via iMessage. At about this time, Patient A was 16 years old and had moved schools to attend sixth form. They began exchanging iMessages on 31 December 2013, with multiple messages being exchanged on 2 January 2014 and subsequently on most days in 2014, discussing more personal topics such as Patient A's relationship with her parents, bullying and mental health. From that point on their communication was primarily by iMessage, with the occasional email message, typically when forwarding something.

25. In the Record of Determinations, the Tribunal summarised the further factual background from this point as follows:

> "25. On 11 October 2014 Patient A arranged to meet Dr Hughes while she was visiting a University in London as a prospective student. At this time Patient A was aged 17 and in year 13. Dr Hughes had completed his medical training and was working in London as a surgical trainee. This was the first time Patient A and Dr Hughes had seen each other since February 2012 when she was having a procedure [in] the hospital.
>
> 26. On 23 October Dr Hughes messaged Patient A and asked if she would be interested in a romantic relationship with him. Patient A accepted and they arranged to meet when she went to London for a meeting with a University.
>
> 27. On 27 October 2014 Patient A arranged to meet Dr Hughes in London again. Dr Hughes kissed Patient A. The relationship continued with extensive messaging on a daily basis and of an increasingly personal and sexual nature.
>
> 28. Between 27 and 28 December 2014 Dr Hughes was invited to stay at Patient A's family home by her parents. Dr Hughes and Patient A kissed, which Patient A's parents were unhappy about. They exchanged Christmas presents, including green socks which had become an 'in joke' between the two.
>
> 29. Patient A visited Dr Hughes on 1 January 2015 for the day. They spent the day at the Tate Modern and then engaged in kissing and some limited sexual activity at Dr Hughes' flat before Patient A travelled home.
>
> 30. Dr Hughes was invited to stay at the family home again on 24 January 2015 and Patient A once again went into

his room. Patient A stated that after Dr Hughes left she was told off by her parents.

31. Patient A went to stay with Dr Hughes at his flat in London on a further six occasions - 25 January, 6 and 7 February, 18 and 19 February, 6 to 7 March, 9 to 12 April and 1 to 3 May 2015. On each occasion sexual activity occurred, but not sexual intercourse. Patient A and Dr Hughes messaged extensively about whether or not she wanted to have sexual intercourse before marriage and why she felt that way. During this period Patient A and Dr Hughes sent messages to each other describing sexual acts and fantasies which they described as 'daydreams'. At the time, Patient A was still aged 17.

32. Dr Hughes attended Patient A's 18th birthday party on 26 May 2015, having been invited by her parents. The following weekend, 29 May 2015, Patient A visited Dr Hughes in London and they had sexual intercourse on several occasions.

33. Patient A visited Dr Hughes again between 22 and 25 June 2015 and they had sexual intercourse several times. They had a discussion about marriage and the future of their relationship, which they disagreed about. Following this visit, they agreed to take a break from the relationship over the summer holiday.

34. Following this break, Dr Hughes and Patient A met up several more times, including after Patient A moved to London in September 2015 to attend University, however the relationship did not begin again. There was some further sexual activity in early 2016 but the relationship did not resume and there was [no] sexual intercourse. The messages and emails become less frequent over the course of 2016 and the last contact between them was an email from Patient A to Dr Hughes on 13 May 2018 asking to meet up, but Dr Hughes did not reply. Throughout this period, Patient A was engaging in deliberate self-harm and struggling with an eating disorder which she stated was a result of the relationship breaking down.

35. Patient A reported the matter to the Metropolitan Police in June 2020 and was interviewed on 4 January 2021. Dr Hughes was interviewed by police in April 2021 and provided a prepared statement. The investigation was closed with no further action against Dr Hughes."

26. It was shortly after Patient A's reporting of the matter to the Metropolitan Police that concerns were raised with the GMC about Dr Hughes's relationship with Patient A. The case was considered and, after investigation by the GMC, was referred to the Medical Practitioners Tribunal Service ("the MPTS") under Rule 17 of the General

Medical Council (Fitness to Practise) Rules 2004 ("the FTP Rules"), so that the MPTS could convene a medical practitioners tribunal to:

i) consider various factual allegations made the GMC against Dr Hughes on the basis of its investigation;

ii) determine whether the facts admitted and/or found proved amount to misconduct and, if so, whether by reason of that misconduct Dr Hughes's fitness to practice is impaired; and

iii) if so, what appropriate and proportionate sanction should be imposed.

The hearing before the Tribunal and the Record of Determinations

27. The hearing before the Tribunal took place over eight days between 8 and 17 January 2025, during which the Tribunal made its determinations on the facts and found that Dr Hughes's fitness to practice was impaired. The Tribunal then adjourned the hearing, reconvening for a further two days on 3-4 June 2025, at the end of which the Tribunal made the determination on sanction against which the Authority is appealing.

28. The Tribunal was comprised of a legally qualified chair, a lay tribunal member, and a medically-qualified tribunal member registered with the GMC. It was assisted at each of its sessions by a Tribunal Clerk. In accordance with Rule 41 of the FTP Rules, the hearing was held partly in public and partly in private.

29. At the hearing before the Tribunal, the GMC was represented by Ms Colette Renton and, as I have already noted, Dr Hughes was represented by Ms Harris.

30. The decisions of the Tribunal recording its determinations on the facts, fitness to practise, and sanction were recorded in a Record of Determinations that was handed down in private but also, as it concerned Dr Hughes's misconduct, published in redacted form after the hearing. The Record of Determinations includes:

i) at paragraphs 1-62, the Tribunal's Determination on Facts made on 15 January 2025;

ii) at paragraphs 63-138, its Determination on Fitness to Practise made on 17 January 2025;

iii) at paragraphs 139-189, its Determination on Sanction made on 4 June 2025; and

iv) at paragraphs 190-200, its Determination on Immediate Order (namely, whether the sanction of suspension should apply immediately or after an interval of 28 days on which written notification of the decision on sanction is served, unless he lodges an appeal).

31. Dr Hughes did not lodge an appeal.

32. The Authority makes no complaint about the Tribunal's Determination on Facts or its Determination on Impairment. I will deal with each of these as briefly as I can before turning to the Determination on Sanction.

33. The Tribunal also made a Determination on Immediate Order, about which no complaint is made. I also deal with that briefly below.

34. The GMC made sixteen allegations against Dr Hughes, which were set out at paragraph 8 of the Record of Determinations. At the outset of proceedings, in accordance with Rule 17(2)(d) of the FTP Rules, Dr Hughes admitted all but three of the allegations. In accordance with Rule 17(2)(e), the Tribunal announced the admitted allegations as admitted and found proved.

35. I will first set out, therefore, the admitted allegations, and then note the two factual questions that the Tribunal was called upon to determine in relation to the three outstanding allegations. It is worth noting at this stage that in relation to each of the two open factual questions, the GMC failed to prove its case. Accordingly, the summary below sets out the full set of proven allegations on which the Tribunal based its conclusion that Dr Hughes's fitness to practise was impaired. Dr Hughes maintains that the Tribunal's rejection of the GMC's case on the three unproved allegations is relevant to the Tribunal's decision on sanction, and so I will deal with those after I set out the proved allegations.

36. Paragraph 62 of the Record of Determinations sets out the allegations that the Tribunal found to have been admitted and therefore proved (using the same numbering for the individual allegations as in paragraph 8 of the Record of Determinations):

> "That being registered under the Medical Act 1983 (as amended):
>
> 1. On or around 10 March 2011 you observed a procedure on Patient A (a minor) at Bristol Royal Hospital for Children. After Patient A's discharge in April 2011, you sent messages to Patient A between 2011 and November 2013 as set out in Schedule 1, which were inappropriate in that:
>
> a. …
>
> b. the messages were not part of Patient A's medical care; …
>
> c. you sent the messages directly to Patient A and to no one else; …
>
> d. … .
>
> 2. From December 2013 you used your professional position to pursue an improper emotional relationship with Patient A in that you sent messages to her, as set out in Schedule 1, which were inappropriate in that:

a. you were aware that Patient A had developed personal feelings for you from …:

i. …

ii. December 2013; …

b. the messages were not part of Patient A's medical care; …

c. you sent the messages directly to Patient A and to no one else; …

d. the nature of your messages became personal; …

e. your messages became more frequent. …

3. You sent Patient A messages from 23 October 2014 to 2015 as set out in Schedule 1 with the intention of pursuing a sexual relationship with Patient A. …

4. You entered into a sexual relationship with Patient A in that you, on one or more occasions, from:

a. October 2014 kissed Patient A; …

b. February 2015 engaged in sexual activity with Patient A; …

c. 29 May 2015 engaged in sexual intercourse with Patient A. …

5. Your actions at paragraph 3 were sexually motivated. …

6. You knew that Patient A was vulnerable at all material times for the reasons set out in Schedule 2 below. …"

37. This passage refers to a Schedule 1 and a Schedule 2. Schedule 1 set out the full text of emails and iMessages exchanged between Dr Hughes and Patient A between 15 March 2011 and 19 February 2017. The Schedule is over 1,700 pages in length, with a degree of repetition of the email messages when reproducing threads of email. The vast majority of the messages exchanged are iMessages. As I have already noted, the messages began with an email message from Dr Hughes's personal email account on 15 March 2011 (see [12] above). The first iMessage was sent by Dr Hughes to Patient A on 28 October 2013 (see [22] above). The next exchange of iMessages was on 31 December 2013, and from that point until the messages stopped in September 2017, the vast majority of them were iMessages.

38. Schedule 2 gives two bases on which Dr Hughes knew that Patient A was vulnerable, namely:

i) her age, in relation to messages sent before she turned 18 in mid-1997; and

ii) her mental state, due to her having an eating disorder, which she had discussed with Dr Hughes, and having committed more than one incident of self-harm, which she had also discussed with him.

39. The three allegations that the Tribunal found not to have been proved by the GMC were as follows (using the numbering in paragraph 8 of the Record of Determinations):

i) allegation 1(a): during the period between Patient A's discharge in April 2011 and November 2013, when Dr Hughes was sending to Patient A the messages set out in Schedule 1 that were not part of her medical care, the messages were inappropriate in that he used his professional position to pursue an improper emotional relationship with Patient A;

ii) allegation 1(d): during the period between Patient A's discharge in April 2011 and November 2013, when Dr Hughes was sending to Patient A the messages set out in Schedule 1 that were not part of her medical care, the messages were inappropriate in that Dr Hughes was aware from April 2013 that Patient A had developed personal feelings for him; and

iii) allegation 2(a)(i): from December 2013, Dr Hughes used his professional position to pursue an improper emotional relationship with Patient A in that he sent her the messages set out in Schedule 1, which were inappropriate in that he was aware that Patient A had developed personal feelings for him from April 2013.

40. There is clearly some overlap between allegation 1(d) and allegation 2(a)(i), each allegation depending on the factual question of whether Dr Hughes was aware from April 2013 that Patient A had developed personal feelings for him or whether, as he admitted, that he was only aware of this from December 2013.

41. Accordingly, at paragraph 10 of the Record of Determinations, the Tribunal noted that there were two factual questions that the Tribunal was required to determine, namely:

i) whether Dr Hughes used his professional position to pursue an improper emotional relationship with Patient A between 2011 and November 2013; and

ii) whether he was aware from April 2013 that she had developed personal feelings for him.

42. As I have already indicated, after considering the evidence over a number of days, the Tribunal resolved each of these questions in the negative. Accordingly, it found none of the three allegations proved that were not admitted by Dr Hughes. Dr Hughes says that this is relevant to the Tribunal's ultimate decision on sanction.

43. In terms of witness evidence, the Tribunal had a witness statement from Patient A dated 14 December 2022. As a result of Dr Hughes's admissions, she was not called to give oral evidence. Dr Hughes provided his own witness statement dated 17 December 2024 and gave oral evidence at the hearing before the Tribunal.

44. In addition, the Tribunal had documentary evidence provided by the parties, which included but was not limited to:

    i) the emails and iMessages exchanged between Dr Hughes and Patient A during the relevant period;

    ii) email messages between Dr Hughes and/or Patient A and others, such as Patient A's mother, her grandparents, her brother, her carer, and Dr Hughes's roommate; and

    iii) the three-page prepared statement dated 19 April 2021 given by Dr Hughes to the police.

45. The Tribunal gave itself directions at paragraphs 14-18 of the Record of Determinations about matters such as the burden and standard of proof (the burden resting on the GMC and the standard being the balance of probabilities), the proper approach to witness evidence, the ability to draw reasonable inferences from the facts, the importance of avoiding speculation, and the manner in which the Tribunal was permitted to take Dr Hughes's good character into account when assessing (i) his credibility and (ii) the likelihood that he had done what was alleged and not admitted.

46. At paragraphs 20-35 of the Record of Determinations, the Tribunal set out further relevant factual background that was either admitted by Dr Hughes or agreed between the parties. At paragraphs 36-50, it set out its analysis of the evidence relevant to allegation 1(a), concluding that the allegation was not proved. At paragraphs 52-59, it set out its analysis of the evidence relevant to allegations 1(d) and 2(a)(i), concluding that those allegations were not proved.

47. The Tribunal then set out its overall determination on the facts at paragraph 62, which I have reproduced, in relation to the allegations admitted and found proved, at [36] above.

48. The Tribunal then turned to its determination on the question of whether, by reason of Dr Hughes's proven misconduct, his fitness to practise was impaired. For this purpose, it took into account all of the evidence it had considered at the facts stage of the hearing, both oral and documentary. It also took into account two reflective statements provided by Dr Hughes, dated 30 January 2024 and 30 September 2024. In addition, it received further evidence as follows:

    i) eight testimonials from colleagues of Dr Hughes;

    ii) certificates for four Continuing Professional Development (CPD) courses completed by Dr Hughes between 4 November 2020 and 6 September 2024 on reflective writing skills for appraisal and CPD, recognition, avoidance, and management of boundary violations and sexual exploitation, medical ethics, and maintaining professional boundaries; and

    iii) evidence of completion of the Professional Competence Scheme of the Royal College of Surgeons in Ireland.

49. The Tribunal heard submissions from Ms Renton on behalf of the GMC and from Ms Harris on behalf of Dr Hughes. It then reminded itself of the legal principles that

apply to the impairment stage of these proceedings, including that there is no burden or standard of proof and that the decision as to impairment is simply a matter for the Tribunal's judgment.

50. At paragraph 109, the Tribunal reminded itself of the test for impairment established by Dame Janet Smith in the Fifth Report from the Shipman Enquiry (9 December 2004), as adopted by the Administrative Court in the case of *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant* [2011] EWHC 927 (Admin) ("*Grant*") at [76], namely, whether the doctor's fitness to practise is impaired in the sense that he or she has in the past and/or is liable in the future:

    i) to act so as to put a patient or patients at unwarranted risk of harm; and/or

    ii) to bring the medical profession into disrepute; and/or

    iii) to breach one of the fundamental tenets of the medical profession; and/or

    iv) to act dishonestly.

51. The Tribunal noted that the GMC's case was that Dr Hughes's fitness to practices is impaired on the second and third of the four possible bases set out in *Grant* at [76].

52. The Tribunal bore in mind Dr Hughes's acceptance that his actions, complained of by the GMC and found proved by his admissions, amounted to misconduct.

53. The Tribunal accepted the GMC's position that Dr Hughes's misconduct was a serious departure from paragraph 25 of the 2006 edition of *Good Medical Practice* ("*GMP*"), which was relevant during the period 2011-2013, and from paragraph 53 of the 2013 edition of *GMP*, which was relevant for the remaining period of the relationship. *GMP* is the authoritative guidance published by the GMC describing the conduct and standards expected of all doctors registered with the GMC. The Tribunal found, as Dr Hughes accepted, that the relationship at the outset was a departure from the guidance on maintaining professional boundaries applicable to medical students at that time.

54. At paragraph 114 of the Record of Determinations, the Tribunal considered the fact that at the outset of Dr Hughes's interactions with Patient A, he was a medical student, relatively young, and inexperienced, and that at the time of the romantic and sexual relationship he was a junior doctor. The Tribunal reminded itself that guidance at the time stated clearly that a medical student is held to the same standard as a registered doctor and must be aware that a patient may see them as being in the same position of responsibility. Accordingly, the Tribunal concluded that Dr Hughes's relatively junior position from the outset and during the relevant period did not significantly diminish the seriousness of his actions.

55. The Tribunal looked with some care at Dr Hughes's approach to the professional guidance applicable to him at the time, setting out its analysis and findings on this aspect at paragraphs 117-121. In short, it was clear to the Tribunal that Dr Hughes recognised early on that the guidance presented a potential barrier to a romantic (and, in due course, sexual) relationship with Patient A, but he sought to persuade himself that he was staying on the right side of the line. The Tribunal accepted that Dr Hughes

did not deliberately flout the guidance, but his approach, namely, seeking to rationalise his position and discounting contrary advice (for example, from a friend and fellow doctor who expressed her negative view of the situation by saying to him, "Three letters Cian: GMC"), was clearly of concern in relation to risk and whether his fitness to practise was impaired.

56. At paragraph 122 of the Record of Determinations, the Tribunal found that a number of factors significantly increased the seriousness of Dr Hughes's misconduct:

    i) Patient A's age at the time, in particular that she was 17 when the romantic and sexual relationship began;

    ii) Patient A's poor mental health, which Dr Hughes accepted he was aware of at the time;

    iii) the power imbalance in the relationship as a result of Dr Hughes's professional position and the age difference between them; and

    iv) Dr Hughes's approach to the guidelines.

57. At paragraphs 123-124, the Tribunal characterised Dr Hughes's misconduct as follows:

> "123. The Tribunal found that members of the profession would find Dr Hughes' conduct deplorable: in particular that he did not account for Patient A's vulnerability by virtue of her age and mental health. The Tribunal further found that members of the public, fully informed of the facts of the case, would be shocked and concerned by Dr Hughes' conduct.
>
> 124. The Tribunal therefore concluded that Dr Hughes' conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to serious misconduct."

58. The Tribunal turned, then, to the question of impairment of fitness to practise, which it analysed at paragraphs 125-137.

59. At paragraphs 126-130, the Tribunal considered whether the misconduct was remediable. At paragraphs 131-133, it considered the "risk of repetition", namely, whether Dr Hughes might in the future engage in similar misconduct. At paragraphs 134-137, it considered the test in *Grant*.

60. In relation to whether the misconduct was remediable, the Tribunal reminded itself that sexual misconduct was harder to remediate than, for example, clinical failures and that, to whatever extent Dr Hughes undertook personal remediation, it is difficult to remediate the damage done by his misconduct to public confidence in the medical profession. The Tribunal accepted Ms Harris's submission that Dr Hughes's junior position and inexperience should be considered when considering whether his conduct is remediable.

61. The Tribunal noted that Dr Hughes had undertaken a range of appropriate and targeted courses on professional boundaries and medical ethics over the prior four

years and that he had made full and appropriate reflections on his actions, including how he would manage a similar situation in the future. It found that he had shown significant insight into his misconduct, learnt from the situation, and in the future would be able to prevent the initial boundary violation. It was satisfied that Dr Hughes had remediated to the extent that it was in his power to do so.

62. As to the risk of repetition, the Tribunal bore in mind that more than ten years had passed since the relationship between Dr Hughes and Patient A had ended, without any suggestion that Dr Hughes has engaged in any similar behaviour (nor was there any evidence of any such behaviour before his relationship with Patient A). The Tribunal found that Dr Hughes had significantly improved, and it noted the testimonials which spoke of his increased experience. It considered that he now had the skills to avoid such boundary violations in the future. It also noted the chastening effect of these proceedings on him. While it remained concerned about his rationalising approach to the guidance at the time of his developing relationship with Patient A, the Tribunal considered that his significant remediation, well-developed insight, and experience of these proceedings all meant that the risk of repetition of misconduct was low.

63. Finally, in relation to the test in *Grant*, the Tribunal accepted that the second and third bases were engaged in this case. It bore in mind Ms Harris's submissions that there was not always a need to make a finding of impairment to mark the public interest and there were factors in this case that differentiated it from other more serious cases of sexual misconduct. It took into account the specific facts of the case, including the mitigating aspects, but it considered that it was nonetheless required, given the serious nature of the misconduct, including the sexual misconduct, to mark it with a finding of impaired fitness to practise. It considered this necessary to maintain public confidence in the profession and to uphold proper professional standards.

64. Accordingly, at paragraph 138, the Tribunal found Dr Hughes's fitness to practise to be impaired. Having reached this stage on 17 January 2025, the Tribunal adjourned the hearing to 3 June 2025 for the sanction determination, announcing its decision on sanction on 4 June 2025.

65. At the sanction stage, the Tribunal received further evidence, including two supplemental bundles. It heard submissions on behalf of the GMC and on behalf of Dr Hughes. Ms Renton's submissions for the GMC are summarised at paragraphs 142-148 of the Record of Determinations, and Ms Harris's submissions for Dr Hughes are summarised at paragraphs 149-155.

66. The GMC's position was that the appropriate and proportionate sanction, given the seriousness of the misconduct, was erasure. Nothing less would be sufficient to uphold public confidence and professional standards.

67. Dr Hughes's position was that, in light of the unique circumstances of this case, including the Tribunal's findings about the specific facts, Dr Hughes's exemplary professional record apart from this misconduct, his full acceptance of his behaviour, his well-developed insight and reflection, and the significant passage of time since the relevant events, a suspension, potentially with a review period, would sufficiently uphold public confidence while allowing Dr Hughes to contribute to the future of the

medical profession. Erasure would be disproportionate "given the nuanced facts and the extent of Dr Hughes's insight, apology, and remediation".

68. At paragraphs 156-159, the Tribunal directed itself as to the proper approach to determining sanction, which was a matter for it alone, exercising its judgment. It was to have regard to its findings of fact, its findings of misconduct and impaired fitness to practise, and the submissions made on behalf of each party, paying particular attention to the *Sanctions guidance for members of medical practitioners tribunals and for the General Medical Council's decision makers*, published by the GMC and the MPTS, as in use from 5 February 2024 ("the *Sanctions Guidance*").

69. The Tribunal directed itself that, when considering sanction, it must have regard to the statutory overriding objective, which is: (i) to protect, promote, and maintain the health, safety, and wellbeing of the public; (ii) to promote and maintain public confidence in the medical profession; and (iii) to promote and maintain proper professional standards and conduct for members of that profession. It must consider that objective as a whole, not giving excessive weight to any one limb. The purpose of sanctions was not to be punitive but to protect the public interest. It was also to have regard to proportionality and to weigh Dr Hughes's interests with those of the public.

70. At paragraphs 161-163, the Tribunal considered the mitigating factors, which it found to be the following:

    i) Dr Hughes had made admissions at the start of the hearing;

    ii) he had apologised sincerely to those involved in his misconduct;

    iii) he had completed a wide range of appropriate CPD courses;

    iv) he had remediated his misconduct to the extent that it was in his power to do so;

    v) his colleagues had provided a range of testimonials stating that he was a competent doctor and that his contributions were highly valued;

    vi) no other complaints had been made about Dr Hughes either before or after the misconduct at issue;

    vii) the incidents had taken place over ten years ago, and Dr Hughes had demonstrated increased maturity since that time; and

    viii) Dr Hughes had cooperated with the police investigation and the GMC investigation.

71. The Tribunal considered it significant that whilst Dr Hughes's relationship with Patient A was improper and arose because Dr Hughes had met her through his professional position, it had not developed into an emotional or physical relationship until a considerable time after Dr Hughes's professional involvement with Patient A ceased.

72. At paragraphs 164-165, the Tribunal noted that it did not find any aggravating factors that went beyond its findings as to the serious features of the misconduct, which I have summarised at [56] above.

73. The Tribunal then considered the appropriate sanction, starting with the least restrictive, the options being:

    i) taking no action despite the finding of impaired fitness, which the Tribunal noted was only appropriate in exceptional circumstances and was clearly not appropriate in this case;

    ii) imposing conditions on Dr Hughes's registration, which the Tribunal considered would not be a sufficient or proportionate sanction to satisfy the public interest, given Dr Hughes's serious departures from the principles set out in *GMP*;

    iii) suspension for a period of up to 12 months; or

    iv) erasure from the register.

74. At paragraphs 170-183, the Tribunal set out its analysis of whether an order of suspension would be appropriate or whether, instead, erasure was required. It noted that it bore in mind paragraphs 91-93 and 97 of the *Sanctions Guidance*, which bear on whether suspension will be the appropriate sanction. In this regard, it reminded itself of its findings at paragraphs 123 and 124 (which I have set out in full at [57] above) that Dr Hughes's conduct was "deplorable", that a fully informed member of the public would be "shocked and concerned" by it, and that it fell so far short of the standards reasonably expected of a doctor as to amount to serious misconduct.

75. The Tribunal also considered paragraphs 142-146 of the *Sanctions Guidance*, which bear on whether erasure will be the appropriate sanction. The Tribunal considered that these paragraphs are relevant because these provisions deal with cases where a doctor has used their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them and where a patient is vulnerable (for example, by reason of age, being under 18 years old, or mental health).

76. The Tribunal then considered paragraphs 108-109 of the *Sanctions Guidance*, which deal with cases where a doctor's misconduct is so grave as to be incompatible with continued registration as a doctor. Paragraph 109 sets out a non-exhaustive list of factors that, if present, may indicate erasure is appropriate.

77. The Tribunal rejected the submission made by Ms Renton that Dr Hughes had shown a "blatant disregard" for the guidance relating to inappropriate relationships, noting its finding that he did have regard to the guidance at the time he was considering entering into a relationship with Patient A but persuaded himself that the guidance permitted the relationship.

78. The Tribunal considered that Dr Hughes had abused his professional position and entered into an improper relationship with a vulnerable patient whom he had met in a professional capacity, but it did not consider, bearing in mind the nature of the

relationship as revealed by the messages exchanged between Dr Hughes and Patient A, that Dr Hughes had exploited Patient A's vulnerability.

79. While the Tribunal considered that Dr Hughes's misconduct had had a significant impact on Patient A, it bore in mind that the relationship had not developed during Dr Hughes's professional contact with Patient A. Had it been otherwise, his misconduct would have been more serious.

80. At paragraphs 178-179, the Tribunal summed up the position as follows:

> "178. Having carefully considered the options before it, the Tribunal reached the conclusion that the facts of this case were finely balanced and that there were a number of serious factors within the misconduct which could denote that erasure would be the appropriate sanction. However, the Tribunal bore in mind the mitigating features: particularly Dr Hughes' admissions and apology; his well-developed insight and remediation and his remorse. The Tribunal accepted Ms Harris' submission on behalf of Dr Hughes that this was a factually nuanced case and that it could be distinguished from other cases of sexual misconduct where erasure was required.
>
> 179. Accordingly, having looked at matters in the round, the Tribunal concluded that this case was not one where the misconduct was 'fundamentally incompatible with continued registration' and that erasure would be a disproportionate response."

81. The Tribunal had further regard to the testimonials that showed Dr Hughes to be a highly regarded, well-liked, and competent doctor. It considered that it was also in the public interest to allow an otherwise good and experienced doctor to remain on the register.

82. The Tribunal determined that a period of suspension would be an appropriate and proportionate sanction, balancing Dr Hughes's interests with those of the public. It would have a sufficient deterrent effect, demonstrating to Dr Hughes, the profession, and the public that his misconduct was unbefitting of a registered doctor and would not be tolerated.

83. At paragraphs 184-187, the Tribunal considered the appropriate length of the suspension, by reference to paragraphs 99-102 of the *Sanctions Guidance*, including the table following paragraph 102. Having regard to the aggravating factors in this case, acknowledging that Dr Hughes's misconduct was a "serious departure from the principles" set out in *GMP*, and that it came "close to requiring a sanction of erasure", the Tribunal concluded that it was necessary to impose the sanction of suspension for the maximum period of 12 months.

84. At paragraphs 188-189, the Tribunal determined that it would direct a review hearing of Dr Hughes's case, to be convened shortly before the end of the suspension period, unless an early review were sought by Dr Hughes or by the GMC.

85. At paragraphs 190-200, the Tribunal set out its reasons for concluding that it was not necessary to make an immediate order of suspension in this case, the effect of this being that Dr Hughes's registration was suspended 28 days after the date on which written notification of the Tribunal's decision was deemed to have been served on Dr Hughes.

86. On 30 June 2025, the GMC convened a meeting of its Panel to consider whether the GMC should consider appealing the Decision under section 40A of the Medical Act 1983. On 8 July 2025 it issued a note confirming its determination that the sanction imposed by the Tribunal was within the reasonable range of outcomes available to the Tribunal and therefore could not be said to be insufficient to protect the public, as a result of which determination the GMC had decided not to appeal the Decision under section 40A.

Legal principles

87. For the purposes of section 29 of the 2002 Act, the Decision is a "relevant decision" in relation to which this court is the "relevant court". Under section 29(4) of the 2002 Act, where a relevant decision is made, the Authority may refer the case to the relevant court if it considers that the decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public.

88. Under section 29(7) of the 2002 Act, where the Authority does so refer a case, the court is to treat it as an appeal by the Authority against the relevant decision even though the Authority was not a party to the proceedings that resulted in the relevant decision. The body that made the relevant decision and the person to whom the relevant decision relates are both to be respondents, which in this case means, of course, the Tribunal (a statutory committee of the GMC, with no separate legal personality) and Dr Hughes, respectively.

89. Section 29(8) sets out the relevant court's powers in relation to such an appeal, which are that the court may:

    i) dismiss the appeal;

    ii) allow the appeal and quash the relevant decision;

    iii) substitute for the relevant decision any other decision that could have been made by the body that made the relevant decision; or

    iv) remit the case to the body that made the relevant decision to dispose of the case in accordance with the court's directions; and

    v) in any such case, make such order as to costs as the relevant court thinks fit.

90. In *Professional Standards Authority for Health and Social Care v Health and Care Professions Council and Andrew Roberts* [2020] EWHC 1906 (Admin) at [3], Foster J notes that it is well-established that CPR Part 52 applies to an appeal by the Authority under section 29 of the 2002 Act and helpfully summarises the principles, derived from case law, applicable to an appeal from a decision of a medical practitioners tribunal. In relation to an appeal by the Authority under section 29 of the 2002 Act, the effect of CPR r 52.21(3) is that the court will allow an appeal if it

decides that the relevant decision subject to appeal was either wrong or unjust because of a serious procedural or other irregularity in the proceedings before the Tribunal. In this case, the Authority does not say that there was a serious procedural or other irregularity in the proceedings before the Tribunal, so the issue raised by each ground is whether the Decision was wrong for the reasons given by the Authority in support of that ground.

91. In *General Medical Council v Jagjivan* [2017] EWHC 1247 (Admin), [2017] 1 WLR 4438 (DC) at [39]-[40], the Divisional Court confirmed that the well-settled principles developed in relation to an appeal by a registrant under section 40 of the Medical Act 1983, as appropriately modified, can be applied to an appeal by the GMC under section 40A. The Divisional Court also set out principles applicable to a section 40A appeal. It is common ground that those principles also apply to an appeal by the Authority under section 29 of the 2002 Act. As in the case of an appeal under section 40A, an appeal under section 29 is by way of review, whereas an appeal under section 40 is by way of re-hearing.

92. Further consideration was given to section 40A appeals in *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879, [2019] 1 WLR 1929 (CA). In *Bawa-Garba* at [61], the Court of Appeal noted that the decision of the medical practitioners panel in that case that suspension rather than erasure of Dr Bawa-Garba was an appropriate sanction:

> "… was an evaluative decision based on many factors, a type of decision sometimes referred to as a 'multifactorial decision'. This type of decision, a mixture of fact and law, has been described as 'a kind of jury question' about which reasonable people may reasonably disagree … . It has been repeatedly stated in cases at the highest level that there is limited scope for an appellate court to overturn such a decision."

93. In *Bawa-Garba* at [67], the Court of Appeal, having considered authorities warning of the need for an appellate court to proceed with caution, particularly in relation to an appeal by way of review rather than re-hearing, where the first instance judge has reached a decision based on their assessment of primary facts, went on to observe:

> "That general caution applies with particular force in the case of a specialist adjudicative body, such as the Tribunal in the present case, which (depending on the matter in issue) usually has greater experience in the field in which it operates than the courts … . An appeal court should only interfere with such an evaluative decision if (1) there was an error of principle in carrying out the evaluation, or (2) for any other reason, the evaluation was wrong, that is to say that it was an evaluative decision which fell outside the bounds of what the adjudicative body could properly and reasonably decide … ."

94. In *Sastry v General Medical Council* [2021] EWCA Civ 623, [2021] 1 WLR 5029, where the Court of Appeal was considering two separate appeals under section 40, Nicola Davies LJ, giving the judgment of the Court, at [108] endorsed the approach of the court in *Bawa-Garba* as appropriate to the review jurisdiction applicable to

section 40A appeals. In that context, she noted that the court in *Bawa-Garba* identified the approach of the appellate court as being supervisory in nature, in particular in respect of an evaluative decision. Determining whether the evaluative decision was "wrong" involved deciding whether it fell "outside the bounds of what the adjudicative body could properly and reasonably decide".

95. In *General Medical Council v Gilbert* [2026] EWCA Civ 53, Bean LJ, giving the judgment of the Court, confirmed at [53] that, in relation to a section 40A appeal, *Jagjivan* must be read in the light of the Court of Appeal's decision in *Bawa-Garba* and then went on to refer to the passage in *Bawa-Garba* at [61], to which I have referred at [92] above. He noted at [56] that in relation to a section 40A appeal, whether the court is conducting a review rather than a re-hearing, the GMC is given only a "limited right of appeal on the ground of 'sufficiency'". He went on to say at [57]:

> "As the [first instance] judge rightly said in the present case …, in a case which concerns sexual misconduct or racist statements the court can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and can attach less weight to the expertise of the Tribunal. Nevertheless, in determining sanction in such cases the Tribunal is making an evaluative judgment to which the court should give a proper measure of respect, in particular when exercising the review jurisdiction under s 40A."

96. For the reasons I have already given, these observations also apply to appeals under section 29 of the 2002 Act.

Discussion

Ground One

97. In relation to Ground One, Mr Hopkins submitted that the Tribunal reached the wrong conclusion that the sanction of suspension was a sufficiently serious sanction given the Tribunal's factual findings and the nature of his misconduct, having made several errors in its reasoning. The Tribunal's errors were as follows:

    i) It failed to have regard to paragraph 148 of the *Sanctions Guidance*, which gives an authoritative steer that where, as in this case, a doctor has abused their professional position and their conduct involves a vulnerable patient, erasure is likely to be appropriate. It did not give reasons for departing from this guidance because it did not have regard to it.

    ii) Suspension was not an "appropriate and proportionate sanction" in this case given that Dr Hughes was not practising as a doctor in the UK before the suspension, and there was no suggestion that he intended to do so in the future. The deterrent effect of suspension, in these circumstances, was therefore diminished compared with a normal case where a registered doctor is unable to continue with their usual practice during the period of suspension.

iii) For similar reasons, the Tribunal was wrong to give significant weight to the factor that it was in the public interest for Dr Hughes to remain on the register.

iv) The Tribunal gave too much weight to the mitigating factors that it set out in bullet points at paragraph 163 of the Record of Determinations (see [70] above). The mitigating factors set out in the second, third, and seventh bullet points, that Dr Hughes had made sincere apologies, that he had completed a wide range of appropriate CPD courses, and that there had been a considerable lapse of time (over 10 years) since the misconduct took place, since which time Dr Hughes had demonstrated increased maturity, were simply aspects of the Tribunal's conclusion set out in the fourth bullet point, that he had remediated his misconduct to the extent it was in his power to do so. The mitigating factor in the fifth bullet point as to the testimonials as to Dr Hughes's competence and the high value of his contributions were not of significant weight given that, as already noted, he was no longer practising in the UK or intending to do so in the near future. The remaining mitigating factors in the first, sixth, and eighth bullet points, that he had made admissions at the start of the hearing, that there had been no other complaints about Dr Hughes before or after the misconduct at issue, and that he had cooperated with the police investigation and the GMC investigation were not capable of reducing the seriousness of his misconduct to a level at which a suspension was a sufficient sanction.

98. Ms Harris, on behalf of Dr Hughes, submitted that the Tribunal's decision on sanction was an appropriate and proportionate response in the circumstances of his case. It was a multifactorial decision, involving a mixture of fact and law, which this court, exercising a review jurisdiction, should give a proper measure of respect. She submitted that the Authority was wrong to submit that the Tribunal failed to have regard to paragraph 148 of the *Sanctions Guidance*, that it gave too much weight to the public interest in allowing Dr Hughes to remain on the register, and that the mitigating factors were insufficient to justify a sanction less than erasure.

99. Ms Harris emphasised the careful approach of the Tribunal to its determination of its factual findings and that, following that careful approach, it found the case to be "factually nuanced". The Tribunal had also found that this case could be distinguished from other cases of sexual misconduct. Ms Harris submitted that the Tribunal's rejection of the three allegations that Dr Hughes did not admit was also relevant to sanction. That rejection showed, for example, that the Tribunal rejected any suggestion of predatory behaviour on the part of Dr Hughes or any suggestion that he sought to develop a personal relationship with Patient A at the time of the therapeutic relationship. The Tribunal had also found it relevant to sanction that Dr Hughes's full admissions had the beneficial effect that Patient A was not required to give evidence before the Tribunal.

100. Having carefully reviewed the Record of Determinations, I have found no error of fact or approach by the Tribunal. This was a difficult case. It was factually nuanced, as the Tribunal found.

101. I reject the Authority's submission that the Tribunal erred by failing to have regard to paragraph 148 of the *Sanctions Guidance*. First, it is clear that the Tribunal had careful regard to the *Sanctions Guidance* to the extent relevant. It specifically referred

to several paragraphs of the *Sanctions Guidance* in the Record of Determinations. It was not required to name every paragraph that it considered. The fact that the Tribunal imposed the lesser sanction of suspension is not evidence that the Tribunal did not have regard to paragraph 148.

102. I also note that paragraph 148 falls under the heading "Predatory behaviour". The Tribunal found that Dr Hughes had not engaged in predatory behaviour in relation to Patient A. Its rejection of the GMC's three allegations that were not admitted by Dr Hughes reinforced that conclusion. Although it is true that paragraph 148 covers conduct involving a vulnerable patient in addition to predatory behaviour, the Tribunal clearly found that Patient A was vulnerable. It had that fact, therefore, firmly in mind.

103. Paragraph 148 indicates that in a case involving a vulnerable patient, "erasure … is likely to be appropriate". This clearly leaves room for there to be cases involving a vulnerable patient where erasure is not appropriate. In any event, the Tribunal acknowledged that this is a case that came close to requiring erasure, despite the lack of a finding of predatory behaviour and despite the mitigating factors. The submission that the Tribunal erred by failing to have regard to paragraph 148 of the *Sanctions Guidance* is not made out.

104. Although at the time of its determination on sanction, Dr Hughes was not practising in the UK or intending to return to practise in the UK in the near future, he remained employed in the health care sector in a role that relied on his background and experience as a medical practitioner. By that time, he was based in Ireland and registered with the Medical Council of Ireland, which, I was told at the hearing, was following the UK proceedings, including this appeal, with interest. It is clear that the sanction of suspension would have (and, it may be presumed, has had) a significant impact on Dr Hughes and his career. I am not persuaded that the Tribunal gave this factor undue weight.

105. I am also not persuaded that the Tribunal gave undue weight to the public interest in Dr Hughes remaining on the register. The Tribunal only mentioned this factor, based on the testimonials it received, at paragraph 180 of the Record of Determinations, after it had already concluded at paragraph 179 that, "having looked at matters in the round", this was not a case where the misconduct was "fundamentally incompatible with continued registration" and that erasure would be a disproportionate response.

106. Finally, I am not persuaded that the Tribunal gave undue weight to the mitigating factors. I bear in mind that this is a review jurisdiction, where the issue is whether the Tribunal reached the wrong conclusion about sanction, notwithstanding the expertise of the Tribunal, its detailed findings of fact having had the benefit of extensive written and oral evidence, and having carried out a multifactorial evaluation, in relation to which this court should show an appropriate degree of deference.

107. For the reasons set out by the Tribunal in its Record of Determinations, I agree with the Tribunal's conclusion at paragraph 178 that this is a factually nuanced case and one that can be distinguished from other cases of sexual misconduct where erasure is required.

108. Accordingly, the appeal fails on Ground One.

Ground Two

109. In relation to Ground Two, Mr Hopkins submitted that the Tribunal was wrong to conclude that Dr Hughes had not exploited Patient A's vulnerability, including her age as well as her physical and mental health issues. In support of this ground, the Authority relies on some of the messages exchanged between November 2014 and August 2015, where the issue of "GMC guidance" is discussed and whether, if their relationship were to become more physically intimate (as, in due course, it did), this would put Dr Hughes on the wrong side of the line. In these messages, Dr Hughes and Patient A also discuss some "rules" or boundaries in relation to the development of their relationship. Although by the time she made her statement, Patient A could no longer remember the precise wording of the rules, they were broadly as follows. Rule 1 appeared to be that there should be no public displays of affection. Rule 2 was that Dr Hughes should not touch certain areas of her body, including her breasts and her "private area". Rule 3 was that there should be no sex before marriage. Patient A in her evidence admitted that she revised her boundaries as she got more comfortable with physical intimacy with Dr Hughes. As I have already noted, they did not progress to full sexual intercourse until shortly after Patient A's 18th birthday. On 16 August 2015, Patient A sent Dr Hughes a message stating:

> "I do regret not making you provide more certainty and actually committing yourself a bit more to what you said about wanting us long term before breaking rule 3."

110. Mr Hopkins invited me to find, on the strength of Patient A's unchallenged evidence and the documentary evidence of the messages, that Dr Hughes did exploit Patient A's vulnerability in order to progress to an inappropriate personal and intimate relationship with her, including full sexual intercourse shortly after her 18th birthday, followed by his ending the relationship around one to two months later.

111. To reinforce this ground, Mr Hopkins submitted, the Authority relied on the following additional factors:

i) Dr Hughes admitted that at all material times he was aware that Patient A was vulnerable;

ii) the admitted and proved allegations against Dr Hughes showed an escalating pattern of behaviour for all but one or two months of which Patient A was a child, having been 13 years old at the beginning of the relationship in March 2011 and just over 18 years old when the intimate relationship effectively ended in June 2015;

iii) the relationship progressed from inappropriate professional contact when Patient A was aged 13 to 16 to deliberate and inappropriate emotional contact when Patient A was aged 16 to 17 and then, finally, to deliberate pursuit of and engagement in a sexual relationship when Patient A was aged 17 to 18; and

iv) Dr Hughes developed a relationship with Patient A's family, which led to his being invited by her parents to stay at their family home and to attend her 18th birthday party.

112. Having regard to all of this, Mr Hopkins submitted, the Tribunal was wrong to have concluded that Dr Hughes did not exploit Patient A's vulnerability. Had it not reached that erroneous conclusion, it would have been bound to conclude on its own findings that the only reasonable sanction was erasure.

113. In response to these submissions, Ms Harris submitted that the Authority was mischaracterising the evidence considered by the Tribunal and relying, in order to support its allegation that Dr Hughes had exploited Patient A's vulnerability, on messages taken out of context. She submitted that a careful review of the evidence, such as that conducted by the Tribunal, shows that Dr Hughes was aware of Patient A's vulnerabilities, took them into account, discussed them with her, and treated her with loving consideration having regard to them.

114. Ms Harris submitted that it was clear from the messages exchanged that Dr Hughes provided Patient A with emotional support. It was clear from his own evidence that he loved her and that he, too, was distressed at the breakdown of their relationship. None of this, she submitted, is to excuse his admitted misconduct. It is, however, relevant to whether he "exploited" her vulnerability in order to achieve physical intimacy with her. She submitted that the Tribunal's finding that Dr Hughes did not exploit Patient A's vulnerability was consistent with the evidence, and therefore it cannot be said to be "wrong".

115. I agree with Ms Harris's submission that the evidence, including the full set of messages exchanged between Dr Hughes and Patient A, as well as the direct evidence of Dr Hughes and of Patient A, is consistent with the Tribunal's conclusion that Dr Hughes's serious misconduct did not include "exploitation" of Patient A's vulnerability in the ordinary sense of that term. His conduct was wrongful for the many reasons identified by the Tribunal and properly justified the significant sanction of suspension of his registration for 12 months, which is the maximum single period of suspension permitted under section 35D(2) of the 1983 Act. However, on a review of the Tribunal's factual findings and the evidence supporting it, I cannot say that the Tribunal was wrong to conclude that Dr Hughes had not exploited Patient A's vulnerability or that its conclusion on this issue was outside the reasonable range open to it on the evidence.

116. It is clear that the Tribunal had regard to the full set of messages exchanged between Dr Hughes and Patient A as well as the direct evidence of each of them. Having regard to the Tribunal's rejection of three of the GMC's allegations, it is not fair to characterise the early part of the relationship between Dr Hughes and Patient A, when she was between the ages of 13 and 16, as part of an "escalating pattern of behaviour" that demonstrated exploitation of Patient A. The Tribunal noted the following at paragraph 162 of the Record of Determinations:

> "…, the Tribunal considered it significant to note that whilst the relationship was improper and arose because Dr Hughes had met Patient A through his professional position, it had not developed into an emotional or physical relationship until a considerable time after Dr Hughes's professional involvement with Patient A ceased."

117. In short, I am unpersuaded that the Tribunal reached the wrong conclusion on the question of whether Dr Hughes had exploited Patient A's vulnerability and for that reason was wrong to impose the sanction of suspension for 12 months rather than the sanction of erasure.

118. Accordingly, the appeal also fails on Ground Two.

Conclusion

119. For the reasons I have given, the Authority's appeal under section 29 of the 2002 Act is dismissed.